Office of the
Children's

"Honouring Their Spirits"

The Child Death Review: A Report
To the
Minister of Family Services & Housing
Province of Manitoba

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Final

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Message from the Co-Chairs

The following is a report of the Special Case Review specific to the unnatural deaths of children in care or receiving services from the Child and Family Services System within one year prior to their death. Those working on this special case review became known as the Child Death Review Team.

During the time devoted to the preparation of this report, each member of the Child Death Review Team has been personally touched by the many and varied circumstances of the foreshortened lives of the children who populate this report.

While the individual identities of these children remain confidential, and information has been summarized in terms of data, themes, observations regarding commonalities, trends and patterns, we have consistently reminded ourselves throughout that the lives and deaths of the children lie behind such information.

As you contemplate the findings and recommendations arising from this review, please do so within the context of our belief that the majority of child welfare workers make their decisions with the best of intentions. As this report demonstrates, best intentions on the part of even the most skillful worker will not be sufficient if not supported by both the families of the children involved and the community-at-large. Our profound belief is that Manitoba's child welfare system can and must serve children in need more effectively and that it can do so through the provision of a seamless delivery of service model. Hopefully, the recommendations contained herein will point the way to improvements to quality of care provided to children within our province's Child and Family Services system.

Each of us, who have devoted the past months to the completion of this review, have been humbled by the challenge of making a contribution to the improvement of services to children who trust that the adults responsible for helping them will do so with the utmost of skill and compassion.

We wish to acknowledge with gratitude those individuals whose care and compassion for children was evident in their willingness to share with us valuable and insightful information and, in so doing, have brought forward the voices of those who are no longer able to speak for themselves.

We also wish to acknowledge the long hours of hard work, perseverance, and heartfelt commitment freely given by the members of the Child Death Review Team throughout this emotionally demanding undertaking.

This report is dedicated to the children of Manitoba and to those whose life stories have touched us all so meaningfully.

Billie Schibler, Children's Advocate
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Child Death Review Team

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Executive Summary

In March 2006, Manitobans were shocked to learn of the death of five-year-old Phoenix Sinclair. Phoenix had been known to the child welfare system.

As a result, a public concern arose in respect to the safety of Manitoban's most vulnerable citizens and the responsiveness of the child protection system to ensure that they were safe from harm.

Under Subsection 4(2) of *The Child and Family Services Act*, the Director of Child Welfare or an Authority has the right to call for an independent investigation in respect to the welfare of a child dealt with under *The Act*. On March 21, 2006, the Honourable Christine Melnick, Minister of Family Services and Housing, called for an independent review of all deaths of children from January 2004 to May 2006, who were in receipt of child welfare services, within one year prior to their death. This review was chaired by Billie Schibler, Manitoba's Children's Advocate, and Jim Newton, Head of Psychology at the Manitoba Adolescent Treatment Centre. The Chairs were supported by a team of four investigators with many years of experience in working with children and families in Manitoba. The Review Team reviewed documents and conducted interviews with agency staff and collaterals related to the unexpected death of 99 children known to the child welfare system.

While the review determined that no child died as a direct result of a breakdown in the provision of child welfare services in Manitoba, it observed, rather, that various factors contributed to a pattern of difficulties that may have led to the death of the child. The review noted that, in many cases, a lack of appropriate community services or the inability to access or coordinate these services created an additional hazard for high-risk children, youth and families.

Manitoba's child welfare system has undergone unprecedented changes stemming from the implementation of the Aboriginal Justice Inquiry-Child Welfare Initiative. Since 2004, up to 70% of children in the care of a child welfare agency have been transferred and are now supported by First Nation agencies. Changes of this magnitude have created new system models, an exciting new way of working with families, but can result in some organizational challenges as new and existing systems move and reshape themselves to accommodate change.

It is within this context that this Special Case Review was undertaken. Observations from the review reflected the need to develop better coordination between agencies and community organizations, and to support areas of particular concern within the child welfare system.

A number of themes have emerged including:

a) Interjurisdictional discrepancies
b) Youth suicide
c) Planning/support for youth leaving the child welfare system
d) Teen risk-taking behaviors
e) Fetal Alcohol Spectrum Disorder (FASD)
f) Awareness of Child Welfare Standards
g) Rural/Northern delivery of service
h) Prevention services

In light of such observations, the Child Death Review Team formulated a number of recommendations, some of which include:

- That the Minister of Family Services and Housing either appoint an independent arbitrator or constitute a committee made up of a representative of each authority, a representative of the Child Protection Branch, and up to three community representatives to act as a dispute resolution body in cases where jurisdiction is in question.

- That the Province of Manitoba adopt '*Jordan's Principle*' of 'Children First' as it relates to ensuring the provision of uninterrupted services to children while awaiting resolution of interjurisdictional funding disputes.

- That the Departments of Health, Justice, Family Services and Housing and Healthy Living conduct a separate and comprehensive review of all youth suicides in Manitoba and that a report be made available by June 2007.

- That the Department of Family Services and Housing develop a policy paper regarding the needs and available supports for youth who are transitioning out of the child welfare system, ensuring that an ongoing support system has been established as they exit the child welfare system.

- That the Addictions Foundation of Manitoba review their current policies concerning treatment models for addicted youth with consideration given to reconsidering policies on 'personal readiness' for treatment.

- That the four Authorities ensure that all agencies have upgraded their CFSIS files to reflect the death of any children in their care, and that these files be maintained in the system on a weekly basis. Funding for this initiative must be made available to ensure compliance in this area.

- That the Child Protection Branch, reaffirm to agency directors the necessity to follow agency standards regarding home visits, ongoing communication with collateral agencies and regular service meetings when using secondary resources as part of a child or a family's case plan.

- That funding be made available through the Department of Family Services and Housing to hire FASD specialists in each child welfare agency. These individuals will help increase opportunities for diagnosis of children suspected of being FASD, as well as work with front-line workers, foster parents and caregivers to develop better case plans for alcohol/substance affected children.

- That a committee comprised of community health professionals, child welfare workers and community members be developed in northern, rural and remote areas to ensure a 'seamless' delivery of services to children and youth living on and off reserve communities.

- That the Department of Family Services and Housing, make available funding, through its prevention programs, to support social and recreational programs encouraging healthy alternatives for children and youth receiving services through a child welfare agency.

A full listing of all recommendations follows this Executive Summary.

The Review Team was also concerned about the politicization of the tragic deaths of children and youth receiving services through the child welfare system. All members of our community must remain mindful of the impact of public statements concerning the death of a child and how that might reflect upon those who are most directly involved. Family members and caregivers in the midst of feelings of guilt, grief and loss find such comments distressing at such a difficult time in their lives. The Review Team commends child welfare agencies whose staff reviewed the circumstances of the death and took action to improve their system in order to strengthen supports to the children and families which they served.

This review reflects situations in which a child died within a year of receiving services through the child welfare system. The causes of these deaths varied in circumstances and variation. In Manitoba, each day children are put at risk by the inability of families, the community-at-large and the child welfare system to act in tandem to prevent child physical and sexual abuse and the victimization of children in our community. In some cases, these issues are long-standing and sufficiently serious enough to cause significant harm to the children, but have not been brought to the attention of the child welfare system nor is it reflected in this study. The community must be willing to work in collaboration with the child welfare system and families to prevent the victimization of children and youth. Perhaps the foregoing should be the subject of another review in order to better understand the scope and extent of this troubling circumstance.

The Review Team believes that this Special Case Review may contribute to changes in the child welfare system that ultimately will provide better protection for all of Manitoba's children.

Manitoba Child Death Review
Full List of Recommendations by Theme

Interjurisdiction

That the Minister of Family Services and Housing either appoint an independent arbitrator or constitute a committee made up of a representative of each authority, a representative of the Child Protection Branch, and up to three community representatives to act as a dispute resolution body in cases where jurisdiction is in question. *(Section 9.4)*

That the Province of Manitoba adopt '*Jordan's Principle*' of 'Children First' as it relates to ensuring the provision of uninterrupted services to children while awaiting resolution of interjurisdictional funding disputes. *(Section 9.4)*

Suicide Prevention

That the Departments of Health, Justice, Family Services and Housing and Healthy Living conduct a separate and comprehensive review of all youth suicides in Manitoba during the past five years and that a report be made available by June 2007. *(Section 6.0)*

That suicide prevention materials be developed which include both culturally sensitive content and which emphasize the development of healthy social connections and healthy self-esteem. This may be achieved through a collaborative relationship with Manitoba Health, Manitoba Family Services and Housing, Manitoba Education and the First Nations Inuit Health Branch. *(Section 6.1)*

That child welfare case managers follow up all reports of suicidal thoughts, actions and/or self-harm behaviours among children receiving services from child welfare agencies by performing an initial assessment themselves and, if required, arrange an assessment by a mental health professional as soon as possible. Based on the assessment of the case manager and the mental health professional, arrangements would be made for prompt follow-up with an appropriate treatment plan that fits the young person's difficulties and life situation. *(Section 6.3)*

That the Department of Health work with the Regional Health Authorities to draft a protocol for assessing and treating children and adolescents who come into hospital emergency rooms with feelings of depression, self-harm or suicide. These protocols should include an assessment protocol, a protocol for ensuring follow-up services are offered and a protocol for immediately informing the local child welfare agency if the safety of that child is in question. *(Section 6.3)*

That in pre-service training, child welfare staff receive specific training on identification of young people with significant adjustment problems, emotional distress and risk of suicide. This training should include information about appropriate resources for intervention. The routine use of this information should be evaluated as part of the normal supervision process and regular updates on this training should be provided. *(Section 6.4)*

That all reports or disclosures of suicidal ideation or attempts be assessed by a mental health professional with a follow-up appointment within 30 days of the first assessment. *(Section 6.3)*

That information about suicide, including information about recognition and intervention related to suicide, be made available to all child welfare staff, parents, caregivers, service providers and relevant professional training programs on an annual basis. *(Section 6.4)*

Mental Health Services

That the Department of Health conduct a review of current child and adolescent mental health services and intervention resources available in rural and remote areas to ensure that children living in these areas do not always have to travel to Winnipeg and Thompson for service. *(Section 8.1)*

That the Department of Health prioritize the hiring of one or more psychiatrists for the Child and Adolescent Treatment Centre in Brandon to provide full in-hospital and out-patient support for families in Brandon and the surrounding areas. *(Section 8.1)*

That the Department of Health provide funding to expand the existing training program for Child and Adolescent Mental Health to First Nations staff using Telehealth facilities. *(Section 8.1)*

That the Department of Health provide funding for a mental health Telehealth Program based in Winnipeg to improve availability of psychiatry and mental health expertise in rural Manitoba and First Nation communities. *(Section 8.1)*

That the Department of Family Services and Housing provide additional funding for five additional beds in the girls' crisis stabilization unit. *(Section 8.1)*

That the Department of Family Services and Housing and the Department of Health work in tandem to develop Mobile Crisis teams and Crisis Stabilization programs in all Manitoba regions that do not currently have such a program. *(Section 8.1)*

Age of Majority Planning

That the Department of Family Services and Housing develop a policy paper regarding the needs and available supports for youth who are transitioning out of the child welfare

system, ensuring that an ongoing support system has been established as they exit the child welfare system. *(Section 8.3)*

That the Department of Family Services and Housing develop a policy paper regarding the needs and available supports for youth with FASD who are transitioning out of the child welfare system. *(Section 8.3)*

That the Child Protection Branch reconsider its policies regarding extensions of care to vulnerable youth with FASD, ADHD, Learning Disabilities and/or mental health issues who would otherwise not qualify for existing external services, to ensure that youth who are unable to live independently with success are provided with the support they need between 18 to 25 years of age. *(Section 8.3)*

That the Department of Family Services and Housing provide baseline funding to the FASD Life's Journey program in Winnipeg, and open a similar program in Brandon and Thompson to provide advocacy and support to young adults with FASD who are emancipating from the child welfare system. *(Section 8.3)*

Children and Youth

That child welfare staff and placement caregivers be provided with training to assist them in recognizing the signs of drug and alcohol abuse, and be made aware of resources that are available to help. *(Section 8.5)*

That where numbers warrant, an adolescent unit within the local child welfare office and intake agencies be developed which will assess and provide services to adolescents. *(Section 8.3)*

That agencies support and endorse the Manitoba Youth Identification Project by ensuring that digital photographs are available for all children in care so that, in a case of an emergency, photographs of the child can be quickly distributed to the police and/or press. *(Section 8.4)*

That agencies undertake to develop a library of digital photographs of children in their care to be used in cases of emergency. *(Section 8.4)*

That once information is received regarding the abuse of a child or adolescent, a complete investigation is conducted to determine the validity of the report regardless of the age of the child. *(Section 8.2)*

That the Department of Family Services and Housing increase funding through prevention programs to specifically fund family counseling for parents and adolescents who are experiencing conflict , which has resulted in the involvement of a child welfare agency. *(Section 8.2)*

That the Departments of Health and Justice commit funding for enough youth addiction treatment beds to ensure that treatment is available to youth within four weeks of referral. *(Section 8.5)*

That the Addictions Foundation of Manitoba reviews its current policies concerning treatment models for addicted youth with consideration given to reconsidering policies on 'personal readinesses for treatment. *(Section 8.5)*

Fetal Alcohol Spectrum Disorder (FASD)

That funding be made available through the Department of Family Services and Housing to hire FASD specialists in each child welfare agency. These individuals will help increase opportunities for diagnosis of children suspected of being FASD, as well as work with front-line workers, foster parents and caregivers to develop better case plans for alcohol/substance affected children. *(Section 8.7)*

That comprehensive training in FASD, specific to the child welfare system, be undertaken by all child welfare agencies. *(Section 8.7)*

Standards

That the Child Protection Branch and the four Authorities ensure province-wide adherence to section 1.1.6 of the Standards Manual regarding Case Transfers. *(Section 9.1)*

That the Child Protection Branch, in consultation with the four Authorities, in reviewing the recommendations from the Snowdon Inquest, ensure that foster parents/ alternate care givers whose residence contains a pool, hot tub, or is in close proximity to a body of water, be required to receive water safety training. Further, the cost of this training would be borne by the Child Protection Branch rather than the caregivers. *(Section 5.1)*

That the Child Protection Branch reaffirm to agency directors the necessity to follow agency standards regarding home visits, ongoing communication with collateral agencies and regular service meetings when using secondary resources as part of a child or a family's case plan. *(Section 9.2)*

That the Child Protection Branch prioritize the timely completion of the Provincial Standards Manual. *(Section 9.3)*

That agencies follow the recommendations of the Schmidt Inquest and make as an agency policy, the reduction of caseloads for new staff during the first six months of their employment with the agency. *(Section 9.3)*

That the Department of Family Services and Housing work towards ensuring that workloads are at a manageable level. *(Section 9.6)*

That all care providers use only government-approved child safety devices (car seats, cribs, playpens, etc.) in the manner for which they were designed and that they do not make any alterations or modifications to them for any reason. *(Section 5.2)*

That child welfare agencies ensure that foster homes have adequate information and comply with existing foster home regulations regarding the safe storage of guns, medications and toxic materials. *(Section 6.4)*

CFSIS

That the Child Protection Branch develop protocols which ensures that child welfare agencies be required to undertake a complete background check when families requiring service move into their jurisdiction or have changed service providers. *(Section 9.1)*

That the four Authorities ensure that all agencies have upgraded their CFSIS files to reflect the death of any children in their care, and that these files be maintained in the system on a weekly basis. Funding for this initiative must be made available to ensure compliance in this area. *(Section 10.0)*

Joint Intake and Response Unit

That the Joint Intake and Response Unit (JIRU) undertake a series of informational training sessions in agencies operating in Winnipeg to provide information about their service. *(Section 9.1)*

Resources/Training

That Competency Based Training (CBT) include a module that focuses on anti-oppressive and anti-racist principles within a strength-based perspective. Given their role in setting the tone and values for their teams, a module should also be included in training for supervisors. *(Section 8.6)*

That the booklet "Guidelines for Reporting Children in Need of Protection" be distributed by the Child Protection Branch to all pertinent professionals on a yearly basis. *(Section 7.1)*

That the Child Protection Branch develop a brief presentation and make it available to all community organizations through an information session on *The Freedom of Information and Protection of Privacy Act* (FIPPA) and Section 18 of *The Child and Family Services Act* with respect to their duty to report protection concerns of children. *(Section 9.2)*

That the Child Protection Branch reinstate standards regarding 'Alerts' in the Program Standards Manual. *(Section 9.1)*

That the Child Protection Branch work with immigrant and settlement organizations in Manitoba to develop workshops on the role of the child welfare system in Manitoba and that these presentations be offered on a regular basis to refugee and immigrant groups. *(Section 8.7)*

That child welfare agencies make available to all interested adolescents, information regarding gay, lesbian, bi-sexual and transsexual resources that are available in the youth's community. *(Section 8.6)*

That the booklet "Guidelines for Reporting Children in Need of Protection" be distributed by the Child Protection Branch to all pertinent professionals on a yearly basis. *(Section 9.2)*

That agency staff be given training in safety planning and skills in de-escalating dangers situations within six months of joining the agency with refresher courses every two years. *(Section 10.0)*

That information or training be offered to all agency staff regarding the location, jurisdiction and practice of all child welfare agencies within the province of Manitoba. This training may also include information regarding agency protocols, contact people and a review of provincial standards regarding case transfers. *(Section 9.1)*

That the Competency Based Training Program include a standard orientation to Child and Family Services including information about *The Act*, standards and operating procedures which child welfare staff would take as mandatory training prior to caseload assignment. *(Section 9.3)*

That child welfare staff be required to complete the first module of the Competency Based Training Program within six months of beginning employment with a child welfare agency. *(Section 9.3)*

That the Supervisors Competency Based Training Program include a module on mentoring front-line staff to ensure their workers are aware of and comply with provincial standards. *(Section 9.3)*

That a provincial directive be issued and that a training module be developed on the "duty to report" and on the role of the Privacy Act with respect to child welfare investigations. *(Section 9.2)*

Rural/Northern/Remote Issues

That funding for prevention and family support programs in the North be increased to ensure that adequate funding is available to provide services that are equitable to services available in the South. *(Section 9.6)*

Crisis Support

That the Child Protection Branch immediately develop a Crisis Debriefing Team that will be dispatched when a child involved with that agency dies or is seriously injured. This team will work closely with agency workers, family, foster parents and other foster children to ensure that all individuals affected by the death are supported and any necessary paperwork is completed. *(Section 10.0)*

That a module in Crisis Debriefing be added to the Competency Based Training (CBT) Program as a supplemental training and that at least one staff member from each agency be encouraged to attend this training. *(Section 10.0)*

That the Department of Family Services and Housing make the sum of $5,000 available to agencies to provide counseling for foster parents and group home staff after the death of a child placed in their home or facility. This funding would be dispersed upon presentation to the Department of Family Services and Housing all counseling bills related to the death of that child. *(Section 10.0)*

That the Department of Family Services and Housing raise their supplemental allowances of up to $1,000, with the submission of receipts, to cover the supplemental costs of: a) funerals, wakes and other traditional ceremonies, and b) travel for immediate family members of children in care to attend the funeral, wake or traditional ceremony. *(Section 10.0)*

That the Child Protection Branch draft standards regarding protocols for supporting agency staff in the event of an unexpected death of a client. These protocols should include: a) protocols for informing staff (current and previous), foster parents (current and previous) and family members of the child, b) up to two paid days' bereavement leave for involved staff after the unexpected death of their client, and c) protocols for supporting all survivors including foster siblings of the child who died. *(Section 10.0)*

That agency staff be given training in safety planning and skills in de-escalating dangerous situations within six months of joining the agency, with refresher courses every two years. *(Section 10.0)*

Children with Disabilities

That the Province of Manitoba develop a more effective method of supporting children with complex medical needs that does not require their family to sign Voluntary Placement Agreements (VPAs) as a condition of receiving appropriate services. *(Section 4.1)*

That the four Authorities develop a sub-committee on medically complex children that will develop policies and practices regarding best methods of supporting these children within the child welfare system. *(Section 4.1)*

Healthy Child Manitoba

That Healthy Child Manitoba develop and distribute information regarding reducing the dangers of SIDS/SUDS to Healthy Baby sites, health clinics and hospitals throughout Manitoba. *(Section 4.3)*

Risk Assessments

That the four Authorities meet to develop a brief risk assessment tool or tools that are representative of the needs of the province or various regional areas. *(Section 7.1)*

That the four Authorities undertake to ensure that formalized risk assessments are conducted for every serviced child under the age of five upon intake, and that these assessments be redone when the child comes into care, is moved to any new foster home placement or if the child is preparing to return to the natural family. *(Section 7.1)*

That copies of the booklet 'Child Protection and Child Abuse Manual: Protocols for Social Worker, be distributed to all child welfare workers in Manitoba. *(Section 7.1)*

High-Risk Women

That the STOP FAS program be expanded to include sites in the highest risk communities in Manitoba and that it be made available to expectant 'high-risk' mothers between the ages of 18 to 25 years of age, on self-referral. *(Section 4.2)*

That where existing perinatal programs or services are available that the mandate be expanded to include voluntary referrals from women aged 18 to 25. *(Section 4.2)*

That a provincial FASD prevention and intervention committee be established to develop innovative ways that child welfare agencies might employ better support to high-risk mothers to reduce the alcohol and drug problems in young people likely to become parents. *(Section 4.2)*

Case Management

That, due to the high number of new or redeployed staff, agencies receive funding for and employ the use of a case management specialist whose duties would be to educate, train and organize case management in accordance with agency philosophy and resources. This individual would be expected to provide this training in the communities to which they provide services. *(Section 9.5)*

Prevention

That a committee comprised of community health professionals, child welfare workers and community members be developed in northern, rural and remote areas to ensure a

seamless delivery of services to children and youth living on and off reserve communities. *(Section 9.5)*

That the Department of Family Services and Housing immediately raise the funding for social and recreational activities for children in care from $1.47 a day to $2.00 a day and that the money be held in an agency pool to provide recreational programming, such as camps, lessons and club fees for children in care. *(Section 7.2)*

That the Department of Family Services and Housing make available, funding through its prevention programs, to support social and recreational programs encouraging healthy alternatives for children and youth receiving services through a child welfare agency. *(Section 7.2)*

That the Department of Family Services and Housing, along with any relevant government departments should make available prevention funding, to support social and recreational programs encouraging healthy alternatives for children and youth receiving services through a child welfare agency. No-cost, family-focused recreational activities should be promoted as healthy alternatives for 'high risk' families. *(Section 7.2)*

That the Child Protection Branch undertake a review of service needs for adolescents, paying particular attention to models of practice that recognize the unique needs of adolescents and that a report outlining the findings be made available to the Department of Family Services and Housing by December 2007. *(Section 8.2)*

That agencies follow up any referrals made to community agencies within three months after an adolescent and/or their family is referred to ensure that services are being used and that no additional supports are necessary. *(Section 8.2)*

That the Department of Family Services and Housing increase funding through prevention programs to specifically fund counseling to children and adolescents who are seen to be in high need for support but are not in the care of a child welfare agency. *(Section 8.2)*

Mobile Crisis Stabilization Unit

That the Winnipeg Mobile Crisis Team be expanded to include one additional evening staff to accommodate youth in crisis. *(Section 8.1)*

That the Department of Family Services and Housing provide additional funding for five additional beds in the girl's crisis stabilization unit. *(Section 8.1)*

That the Department of Family Services and Housing and the Department of Health work in tandem to develop Mobile Crisis teams and Crisis Stabilization programs in all Manitoba regions that do not currently have such a program. *(Section 8.1)*

That the Department of Family Services and Housing and the Department of Health expand funding for out-patient treatment services for children, youth and families such that a child, youth or family is able to access counseling within 12 weeks of referral. *(Section 8.1)*

Health Services

That the Clinic for Alcohol and Drug Exposed Children at the Health Sciences Centre be funded and allowed to provide diagnosis and consultation for youths aged 10 to 18 who are suspected of being prenatally exposed to alcohol and/or drugs. *(Section 8.7)*

That the Department of Health work with the Regional Health Authorities to draft a protocol for assessing and treating children and adolescents who come into hospital emergency rooms with feelings of depression, self harm or suicide. These protocols should include an assessment protocol, a protocol for ensuring follow-up services are offered and a protocol for immediately informing the local child welfare agency if the safety of that child is in question. *(Section 6.3)*

Chief Medical Examiner's Office

That timelines be placed on the completion of CME reports to ensure that reports are available in a timely fashion. This may include retaining outside investigators at times when workloads are higher. *(Section 2.1)*

That when requested, Section 10 reviews be conducted in the community in which the death occurred. *(Section 2.1)*

1.0 Introduction

"We cannot waste our precious children. Not another one, not another day. It is long past time for us to act on their behalf[1]"

Nelson Mandela and Graca Machel
Global Movement for Children

Article 19 of the United Nations-*Convention on the Rights of Children* guarantees the rights of children to grow up in a community free from harm. Yet, in every year, Manitoba's child welfare system intervenes with families to protect hundreds of children from being hurt in their home or community. It is unfortunate that despite all efforts, a small group of children die each year while receiving the services of a child welfare agency. While some died in their home, others died in the community as a result of their involvement in dangerous activities and/or tragic accidents.

In March 2006, Manitobans learned of the death of Phoenix Sinclair, a five-year-old girl who was returned to her mother's care from a child welfare system. Shortly after her return to her family, Phoenix died. Her death was an unnecessary tragedy that reminded Manitobans of the vulnerability of the community and the child welfare system to act to prevent the death of this child, and other children like her.

In response to the death of Phoenix Sinclair, on March 21, 2006, the Honourable Christine Melnick, Minister of Family Services and Housing, called for an independent review of Manitoba's child welfare system. This review was to be conducted in three parts; a review of the case management practices within the child welfare system, an independent review of the death of Phoenix Sinclair and an independent review of the deaths of other children who received services from a child welfare system within a year of their death. This report was charged with reviewing the deaths of children and youth known to the child welfare system who died between 2003 and March 2006.

Subsection 4(2) of *The Child and Family Services Act,* allows the Director of Child Welfare or an Authority to call for an independent investigation in respect to the welfare of a child dealt with under *The Act*. This section reads in part:

> "The director or an authority has the power to "conduct enquires and carry out investigations with respect to the welfare of a child dealt with under this Act."

[1] Except taken from the 1999 World Summit for Children. Further information available from www.unicef.org.

This review was perhaps the first formal review of portions of the child welfare system since the restructuring of Manitoba's child welfare system. In 2003, the Province of Manitoba embarked on a historic transition in the delivery of child welfare services. Since August 2000, the Province of Manitoba, the Manitoba Métis Federation, Manitoba Keewatinowi Okimakanak and the Assembly of Manitoba Chiefs have been working together to restructure child and family services province-wide. Today, families have the choice to receive their child welfare services from their culturally appropriate agency or another agency of their choosing[2] These changes have resulted in major changes as thousands of children have been transferred to Aboriginal agencies who will now provide ongoing support.

Changes of this magnitude cannot help but cause some growing pains as child welfare agencies and staff move to accommodate organizational challenges. Agencies have grown, shrunk and developed to meet the new challenges presented and staff have worked very hard to accommodate these changes. However, the system cannot help but be affected by the enormity of the changes within the child welfare system as families and professionals move to accommodate these changes. This Review was charged with determining if these changes negatively impacted on the lives and deaths of children known to the child welfare system.

The Child Death Review Team was housed in the Children's Advocate office and chaired by Billie Schibler, Manitoba's Children's Advocate, and Jim Newton, Head of Psychology at the Manitoba Adolescent Treatment Centre. The Chairs were supported by a team of four investigators. They were as follows:

Kathy Jones (Team Leader):
Kathy has a BSW from Ryerson Polytechnical University, an MA from the University of Toronto and a Ph.D. from the University of Manitoba. She was seconded to the project from West Region Child and Family Services where she has worked for the past eight years as the Children with Special Needs/Treatment supervisor.

Cybil Williams:
Cybil has a BSW and MSW from the University of Manitoba. Over the past eight years, Cybil has worked in a number of front-line and supervisor positions at Winnipeg Child and Family Services, Awasis and, most recently, Intertribal Child and Family Services.

Jocelyn Greenwood:
Jocelyn has spent five years working in a management capacity for a variety of social service agencies in Manitoba. In past years, Jocelyn has taught counseling skills at Red River Community College and authored a report on Aboriginal issues for the Winnipeg Police Service. She has a special interest in family violence as it relates to Aboriginal women and children.

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[2] Aboriginal Justice Inquiry - Child Welfare Initiative, August, 2001

Dave McDonald:
Dave has a BA from the University of Manitoba and a MSW from the Maritime School of Social Work-Dalhousie University. In 1999, Dave retired from Winnipeg Child and Family Services where he was the Area Service Director for the East area.

Over the four months of the study, this team reviewed deaths of children who had received services by a child welfare system within one year of their death. The team also met with numerous agency personnel and community leaders to discuss issues noted in their review of the deaths of children. In particular, the team was interested in any patterns, anomalies, trends and commonalities in these cases to determine what, if anything, could have improved the quality of life and, perhaps, prevented the death of the children included in this study.

In developing this report, the Review Team adopted a 'healthy community' approach.[3] That is, the review recognized that the child welfare system does not work as an entity separate from the community but instead as a system within the whole community. While children and families may access the services of a child welfare agency, these services must be in addition to services provided by other community agencies, informal networks and families. The goal of the child welfare system is not only to protect children but also to support healthy family functioning. As a result, this report looked not only at the services offered by child welfare agencies, but also at the services offered to children and families within the community-at-large to ensure that the services were available and accessible when needed.

In total, the team reviewed the deaths of 99 children and youth. While this may seem like a large number of deaths, it should be noted that more than half of these deaths were from natural causes including childhood injuries, premature births and birth abnormalities. These children have been included in this report as their deaths provide helpful information as to how to prevent future deaths of this kind in Manitoba.

As expressed by one of our team members, "Systems and reviews of systems, by themselves, do not help people. People help people. People with good hearts who give of themselves, who can relate to the pain and despair of others, who are understanding and caring, who can develop trust and provide hope. It is these people who will make the difference in the lives of families and their children."

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[3] Please see Health Canada (1999). *Healthy Development of Children and Youth: The Role of the Determinants of Health*. Ottawa: Queen's Printer for a further discussion on this theme.

2.0 Methodology

From the direction of the Minister of Family Services and Housing, the Child Death Review Team, was charged with conducting a special review of all deaths of children in Manitoba from 2004 to 2006, who had been involved in the child welfare system. As previously indicated, the project was asked to pay particular attention to patterns, anomalies, trends and commonalities noted in these death reviews to determine what, if anything, could have improved the quality of life and prevented other deaths in similar circumstances.

As the foundation of its work, the study used 'Section 10' reports generated by the Office of the Chief Medical Examiner (CME). A Section 10 report is a review of the child welfare file conducted by staff at the Chief Medical Examiner's office. This report contains information regarding the life and death of that child, as well as the identification of areas that caused the reviewer to have some concern regarding the death. The report was then to be submitted to the Minister of Family Services and Housing for review.

Early on in the study, it became clear that the CME's office had a backlog of approximately 46 files that would not be ready for review by the CDRT within the timelines of the study.[4] Further, these missing files were spread throughout the entire timeline of the study such that there was not one year with a completed set of CME reports. As a result, the study expanded its mandate to include deaths of children in 2003, as all but one of those files was completed.[5] This allowed the study to look at specific patterns within one calendar year.

A total of 147 files were eligible for the study and CME reports (Section 10's) were available and reviewed for 100 files. One file review did not have a CME report and the file review was done by the team.[6] Two files were removed as their relationship with the child welfare system was very minor and did not contribute in any way to the natural death of the child. In all, 99 files were reviewed and formed the basis for this report. The breakdown of the eligible files and those reviewed can be found in Figure 1.

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[4] A fuller discussion on issues related to the CME's office and a fuller definition of 'Section 10' reports can be found in the CME section.

[5] To provide a full data set for 2003 the study did their own review of the one 2003 file that did not have a completed CME report.

[6] Ibid

Figure 1: Breakdown of Eligible Files and Files Reviewed

Eligible Files

Type of Death	Number of Deaths
Natural	76
Suicide	24
Undetermined	12
Accident	13
Homicide	20[8]
Total	145

Files Reviewed

Type of Death	Number of Deaths
Natural	54
Suicide	12
Undetermined	6
Accident	9[7]
Homicide	18
	99

To begin the review, CME reports were divided into two groups:

a) children who had died of natural causes, (Group One)[9]; and

b) children who had died as a result of homicide, suicide, accident and deaths classified as having an undetermined cause (Group Two).

The study used the autopsy reports from the Office of the Chief Medical Examiner, Dr. Thambirajah Balachandra, as its determination of the manner of death.

The review used a Comparative Case Study[10] approach to collect information to support this report. This allowed the review to use a combination of statistical information, interviews and a review of reports pertaining to each child. However, the study only conducted interviews and collected other materials with children in Group Two, as the expectation was that those were the deaths which required a higher level of investigation.

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[7] Ibid

[8] One Homicide was reviewed separately by an independent reviewer and was not reviewed by this team.

[9] Deaths related to Sudden Infant Death (SIDS) or unexplained deaths of babies were put into Group One.

[10] A comparative case study approach develops data into single case studies (in this case, each individual death) and then compares them to other, similar case studies (the group of deaths). Gilgun (1994) suggests that this method is particularly useful in Social Work research for its similarity and applicability to practice.

Statistical Information

Statistical information was drawn from the CME reports as well as from information found on the Child and Family Services Information System (CFSIS), a data base that tracks families involved with the child welfare system. This information explored such issues such as: type of death, circumstances of death, child welfare involvement, placement type and involvement of the child welfare agency. This material was compiled and forms the statistical portion of the study. A copy of these tools can be found in Appendix 1 of this report.

About half of the files reviewed fell into the 'Group One' category; that being the majority of children who had died of natural causes prior to reaching the age of two years. These deaths included children born premature, children born with multiple congenital abnormalities or SIDS-like deaths (Sudden Infant Death Syndrome). A small group of these children developed life-threatening illnesses such as brain tumors, leukemia, kidney failure, and who died from those illnesses. Although the deaths of these children were considered to be unrelated to their involvement with the Child and Family Services system, issues that might have contributed to their death and/or issues that might have enhanced the quality of life for the child and family were examined. In specific cases, some of these files were also used to support issues or themes noted among children who had died of other causes.

Statistics were also compiled regarding the deaths of all children in care in Manitoba from the years 2003 to 2005. These statistics included files of children who were part of the review, as well as those who had been excluded due to the lack of CME reports. This material was compared with death rates in Saskatchewan, as well as with national statistics. In some cases, this proved to be a bit of a challenge as definitions and data collection methods were different in Saskatchewan. Where possible, some adjustments have been made in an attempt to better represent the issues noted. In these cases, footnotes denote the changes made.

Interviews and Meetings with Collaterals

Once statistical information was collected, interviews were conducted with child welfare staff who had been involved with that child at the time of death. In select cases, other collaterals such as agency supervisors, foster parents, third-party care providers, police officers, medical staff and/or family members were also contacted for their views.

To begin with, a brief interview was conducted with the agency representative who was involved with the child at the time of death using a questionnaire developed by team members. These questions included issues such as level of involvement between the agency and the child/family, issues related to placement, needs of the child, worker response to needs and any involvement by outside agencies.

As well, questions were asked related to caseload size, training of workers and adherence to agency standards. These questions had been developed in response to the team's first review of all of the CME files, and represented some of the general issues noted in those reports. A copy of the interview questions is available in Appendix 1 of this report.

In specific cases, additional information was collected regarding the death of a child. Information included a copy of the police report, medical reports and/or interviews with other collaterals. The material gathered and questions posed in those interviews emerged from the data previously collected and helped build a clearer understanding of the circumstances of that death.

Finally, interviews were conducted with various individuals from agencies that supported 'at risk children'. This included representatives from the Winnipeg Police Service, mental health services and various service organizations for children and adolescents. These individuals provided useful information regarding service delivery in Manitoba, as well as ideas for improving the current system. A listing of these individuals is found in the reference section of this report.

As material was collected, various themes emerged and were discussed during weekly meetings. This helped solidify some of the themes to ensure a level of internal consistency. Team members also explored current research or practices that would support the themes noted and these themes comprise the bulk of this report.

2.1 Reports from Chief Medical Examiner

It was requested that the Child Death Review Team use, as its foundation, the reports generated by the Chief Medical Examiner after the death of a child who had some involvement with the child welfare system within a year prior to their death. These reports are mandated as a function of Section 10(1) of *The Fatalities Inquiries Act (1990)* which reads:

> "10(1) If the chief medical examiner received an inquiry report about a deceased child who, at the time of death or within the one year period before the death,
>
> (a) was in the care of an agency as defined in *The Child and Family Services Act*; or
>
> (b) had a parent or guardian who was in receipt of services from an agency under *The Child and Family Services Act*;
>
> the chief medical examiner shall assess the quality or standard of care and service provided by the agency by

(c) examining the records of the agency respecting the child and the parent or guardian; and

(d) reviewing the actions taken by the agency in relation to the child and the parent or guardian."

Unfortunately, in discussions with the CME's office, it became clear that up to 50 of these reports would not be available as they had not been completed. The description of unavailable reports can be found in Figure 2.

Figure 2- Description of Unavailable Reports by Year and Type of Death

2004

Type of Death	Number of Deaths
Natural	1
Suicide	1

2005

Type of Death	Number of Deaths
Natural	17
Suicide	10
Undetermined	5
Accident	4
Homicide	1

2006

Type of Death	Number of Deaths
Natural	4
Suicide	1
Undetermined	1
Homicide	1[11]
Accident	0

The lack of completed reports created some frustration within the Review Team. Under the *Terms of Reference* developed by the Minister of Family Services and Housing, this review would begin with a review of the 'Section 10' reports. In situations in which reports were absent, the review was only able to conduct a cursory review of the death of that child.

Conversations with representatives of the CME's office and the Child Support Branch indicated that about 42 of these cases remain in-process and would not be available within the timelines of the review. Reasons given for not having these reviews completed in a timely fashion are related to workload and complexity of the situation being reviewed.[12] As a result, the Review Team further expanded its database by reviewing completed CME files from 2003.

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[11] This report was reviewed by an independent reviewer and was not be part of this study.

[12] When conducting a file review, staff at the CME's office are required to review all of the files generated for the child being reviewed. In cases such as homicides and/or suicides and/or children that have a lengthy history within the child welfare system, these files can be lengthy and complex. As well, some of these children have files in multiple agencies which may not be evident until the review has begun causing the CME staff to stop and request further files. As a result, these reports are often finished later than reports that have less child welfare involvement.

The lack of completed reports creates a concern in itself. If one is to assume that Section 10(1) of *The Fatality Inquiries Act (1990)* was, among other things, designed to prevent other child in-care deaths, it seems incumbent on the CME's office to ensure that recommendations are provided in a timely fashion. Reports that arrive two to three years after the death may not be as useful to collaterals as those produced more quickly.

It appears from the review of 'Section 10' reports generated over the past few years that an independent review of the death by the CME's office provides valuable information that can enhance the skills of agency staff and contribute to ensuring that future deaths of a similar nature do not occur. Further, and in some cases, recommendations are offered that might protect other children still residing in the home of the deceased child.

John Chudzik (1999) remarked in his report that:

> "Often it isn't until the investigator has gotten well into a review that it becomes evident long after the child's death that children continue to be 'at risk' and/or "in need of protection" and that measures should have been taken much earlier to address the issue especially where children have been left in potentially dangerous living arrangements without agency contact. It may be equally problematic for the agency when the "window of opportunity" for intervention has closed." (pg 7)

Timeliness of reports was first identified by John Chudzik in his 1999 report and were discussed again in the *Findings of the Working Group on the Fatality Inquiries Act* in February 2001. This has resulted in some changes to the CME's office to provide reports more quickly than in the past. However, this has only reduced the wait time for some reports, but has not eliminated the problem.

Recommendation #1

That timelines be placed on the completion of CME reports to ensure that reports are available in a timely fashion. This may include retaining outside investigators at times when workloads are higher.

Compliance Issues

There also seems to be ongoing disagreement with Awasis Agency of Northern Manitoba regarding the manner in which the CME conducts its investigations. It appears that all reviews are undertaken in Winnipeg using child files brought in for that purpose. In 2002, Awasis challenged that reviews conducted in this manner did not adequately capture some of the issues facing Northern communities and requested that the file review be conducted in the community in which the death occurred. This request was declined by the CME's office due to funding constraints. However, the issue continues to be a source of frustration for Awasis who commented in their 2005 Annual Report that:

> "There is an ongoing dispute with the Office of the Chief Medical Examiner's office with respect to the interpretation and implementation of Section 10 of the Fatalities Inquires Act. Awasis takes the position that their investigation should be completed on-site while the CME's position is that it is the responsibility of the agency to send the requested files to their office for review and investigation. The agency has received inappropriate recommendations as a result of such investigation occurring in Winnipeg as opposed to within community. Section 4 reviews had been ordered and completed by the Authority and the Province as a result. These Section 4 reviews have been limited to individual cases; something that agency has objected to with the respective Ministers.
> *(Awasis Agency of Northern Manitoba, Report of 7th Annual General Meeting, 2005, Page 15.)*

It was also noted that there were qualitative differences in the manner of deaths between the North and South agencies, such that a better understanding of some of the limits and constraints of practices in the North would be a consideration in making child protection decisions. It is reasonable therefore, that some of these issues are captured within a 'Section 10' reports. Completing investigations on-site in the North might help the CME provide recommendations that would be more useful to the agencies that work in those communities.

Recommendation #2

That when requested, Section 10 reviews be conducted in the community in which the death occurred.

3.0 Overview

The Review Team undertook to explore some of the overall patterns noted in the death of children and youth in the child welfare system, and children and youth in the province as a whole. The Review was interested in learning whether there were appreciable differences existing in the manner of death of children in the child welfare system. Further, are other issues related to whether the patterns within these deaths were a signal unmet needs within the child welfare system and/or the province as a whole, including services to high-risk children?

The study looked at comparisons between deaths of children in the province of Manitoba and deaths of children in the province of Saskatchewan.[13] The Review Team was interested in determining the patterns of deaths of children in that province. To this end, the study contacted the Office of the Children's Advocate and Child and Family Support Branch in Saskatchewan for information regarding deaths of children in Saskatchewan.

In Manitoba, a total of 138 children and youth known to the child welfare system died from 2003 to 2005. An additional nine children died in the first three months of 2006 but, for the purpose of comparison, were not included in this section of the report. The majority of these children died of natural causes including prematurity, medical conditions and SIDS.[14] Children who committed suicide comprise the second largest group of deaths reviewed by the CME's office, followed closely by children who were the victims of homicides. The number of suicides among youth doubled in 2005; from four in 2003, five in 2004, to 12 in 2005 and the number of homicides increased from five in 2003, five in 2004 and 12 in 2005.

This is a matter of concern although there can be large statistical variations from year to year in low numbers at this level. To consider whether a trend is reliable it is necessary to monitor over a longer period of time. This is a pattern that should be closely monitored.

The larger number of children who died of natural causes remained relatively stable over the years related to this study with 26 children dying of natural causes in 2003, 23 in 2004 and 22 in 2005. Figure 3 summarizes information concerning the cause of death of the children in this study.

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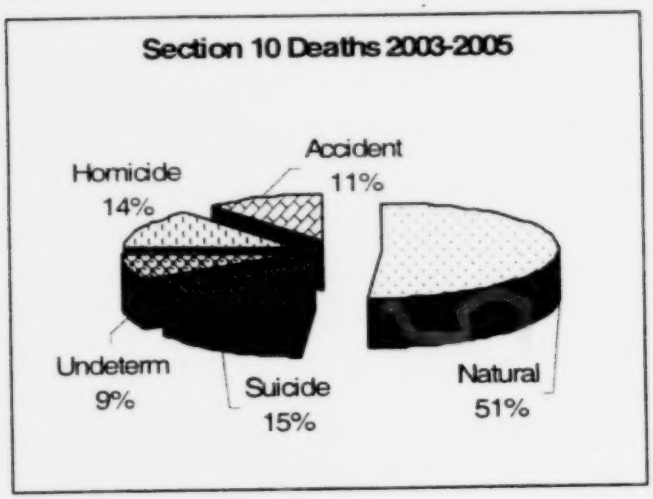
[13] Saskatchewan was chosen due to its similarity in population, economic base and child welfare issues.

[14] Sudden Infant Death Syndrome

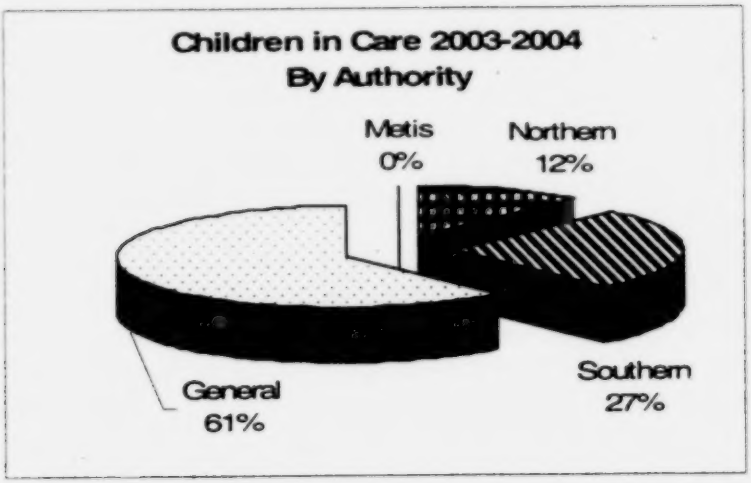
Figure 3: Causes of Deaths of Children Receiving Services Within a Year of Their Death (Section 10 deaths) 2003-2005[15]

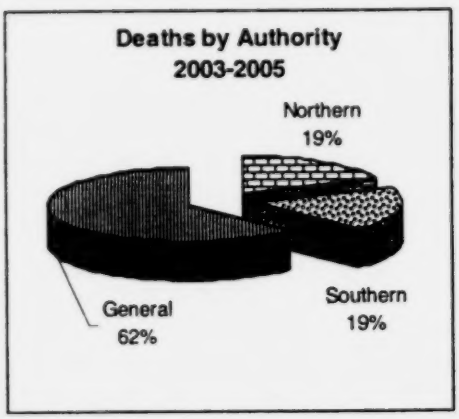


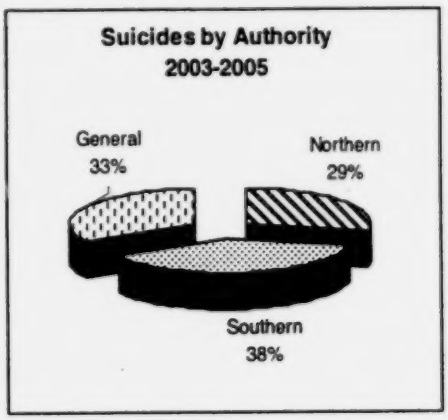
Among all deaths reviewed by the CME's office, 62% of the children were involved with the General Authority[16], the vast majority known to Winnipeg Child and Family Services. Both First Nation authorities had 19% each.[17] The Northern and Southern Authorities appear to have experienced more deaths relative to their total population of children receiving services. More importantly, children from both First Nation Authorities experienced more deaths through suicide than children from the General Authority. While these statistics represent a very small number of youth, this finding is congruent with the findings of the report from Health Canada's Advisory Group on Suicide Prevention which estimates that the rate of suicide among Aboriginal youth to be five to six times higher than that of non-Aboriginal youth.[18] Youth suicide will be discussed in greater detail later in this report.

[15] Data from the Office of the Chief Medical Examiner, Annual Review 2003, 2004, 2005. This includes all Section 10 deaths including those reviewed for the study and those we were unable to review.
[16] The General Authority includes all children with a cultural background other than Aboriginal.
[17] The Métis Authority did not receive its mandate until May 2005 and, as a result, did not have any deaths recorded to its Authority during the years 2003-2005..
[18] Health Canada (2005) *Acting on What We Know: Preventing Youth Suicides in First Nations*. Health Canada.com.

Figure 4: Breakdown by Authority







Deaths Reviewed

With respect to the children who died between 2003 to 2005 and reviewed for this study, it was noted that 70% of the children were not in care[19] at the time of death, with 30% of that group not receiving any child welfare services at the time of their death. All of the homicide, suicide and accidental deaths in this group were explored to determine if increased services and/or removal of the child from the family would have reduced the risk for these children. This group of children, not in the care of a child welfare agency, consisted of 23 deaths (4 accidental, 12 homicides and 7 suicides).

[19] Children deemed 'in care' are children currently in foster care and are not living with their birth parents.

Among the children that were not in the care (but may be receiving services) of an agency at the time of their death, very few 'risk assessments' had been conducted to determine the safety of the home in which the child lived. Using the risk assessment in the child and family intake module, the team determined that had an assessment been conducted that approximately one-third of the cases would have been seen as 'high risk' and an assessment may have helped in developing a plan for the child. Issues regarding the use of risk assessments will be covered in detail later in this report.

Of the children included in this study, 76% were Aboriginal or Métis[20] with 24% non-Aboriginal. These figures closely follow the breakdown of children involved in the child welfare system, but given the fact that Aboriginal people comprise 14% of the total population, it appears that Aboriginal, including Métis children, are overrepresented in both the child welfare system and the deaths of children in general. About half of the children who died were male and half were female.

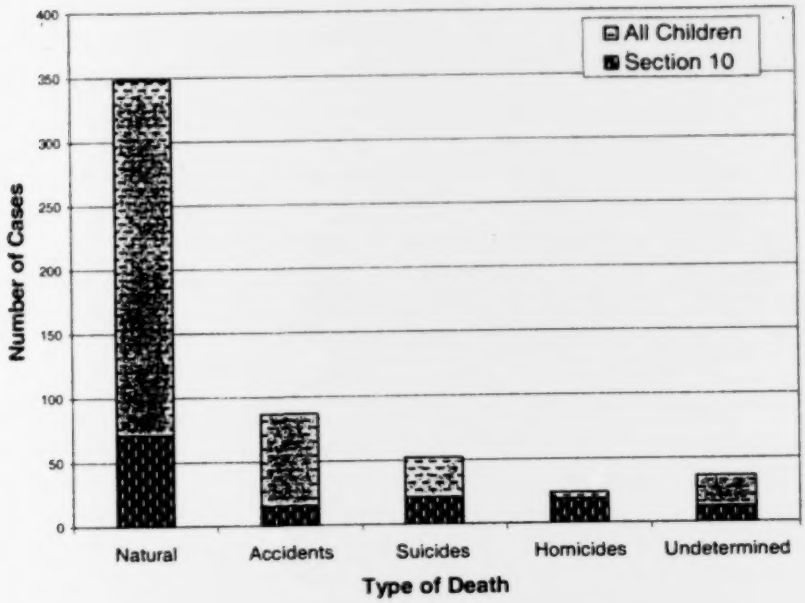
The review noted the patterns regarding the age of child at death. All of the deaths by suicide were between the ages of 9 to 17 years old. In contrast, of the children who were victims of homicides, a little more than 60% (or 12) of the children died as adolescents and a little less than 40% (or 6 children) died as infants and toddlers. No child in the group of children who died of homicide died between 4 to 14 years of age. Similarly accidental deaths occurred most often before the child was three years old (5 deaths) and from 13 to 17 years old (4 deaths). There were no accidental deaths of children between 4 to 12 years of age noted in this study.

Overall Deaths of Children in Manitoba

In comparison with all deaths of children in the province of Manitoba, it was noted that children receiving services through a child welfare agency were at a higher risk for death. Approximately 5% of Manitoba's children received services from a child welfare agency in 2005.[21] Yet, the number of Section 10 deaths is disproportionate to the total number of deaths of children in the province. For example, 19 of the 24 children who died of homicide in this province from 2003 to 2005 were known to a child welfare agency before their death. As many of these children died as a result of their associations outside of their family or placement, this would suggest that the child welfare system had been aware of some of the issues presented and had attempted to help and support the child and family. This may also reflect the overall risk that many children and youth face before their involvement in a child welfare agency and/or some of the risks developed while in the care of an agency.

[20] Previous to 2004 few children in care were identified as from the Métis Nation. To ensure continuity the study coded all First Nation, Aboriginal and Métis children as 'Aboriginal'.
[21] Statistics from the Manitoba Child and Family Support Branch.

Figure 5: Comparison of Overall Deaths of Children in Manitoba 2003-2005 with Children Involved in the Child Welfare System, by Manner of Death[22]



Deaths in Saskatchewan

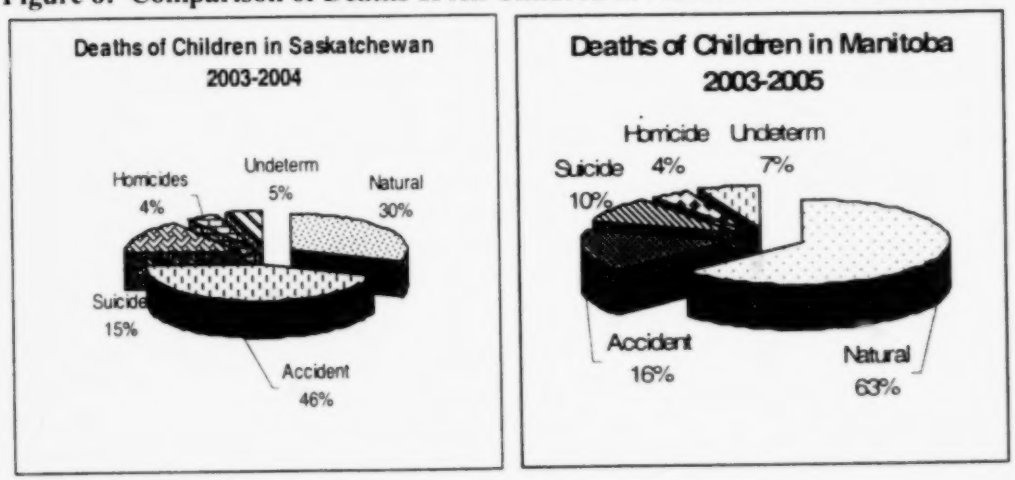
Investigations regarding the death of children involved with a child welfare agency are completed in a somewhat different manner in the province of Saskatchewan. Prior to 2003, the Children's Advocate of Saskatchewan conducted a review of all children involved with a child welfare system within six months of the death. In 2003, the review protocol was changed to review only children 'in the care' of a child welfare agency. This has dramatically reduced the number of children reviewed by the Office of the Children's Advocate to less than 10 reviewed cases per year. However, the Child and Family Services Branch of the Province of Saskatchewan has continued to maintain statistics regarding the death of children involved with CFS within six months of their death. This is somewhat different than the Province of Manitoba which reviews deaths of children involved with CFS for a full year prior to the death. Saskatchewan, however, was used as a comparison to Manitoba due to their similar population size, demographics and economic base.

[22] Figures collected from the Annual Report of the CME's office, 2003, 2004. Figures for 2005 have been provided by the Chief Medical Examiner on the understanding that they be considered as preliminary and subject to change.

When looking at the overall death rates in both Manitoba and Saskatchewan, the charts in Figure 6 show that between 2003 and 2004,[23] Saskatchewan faced a considerably lower number of natural deaths but a much higher rate of accidental deaths. Differences were noted in both real numbers and in ratio to other types of death in each province. These differences may be related to the way in which each province records the count of 'natural' deaths and accidents in Saskatchewan and Manitoba.

While some differential was noted in 'natural' and 'accidental' deaths, little difference was noted in suicide and homicide rates between the two provinces. On a per capita basis, homicide rates were exactly the same in both province and suicide rates were somewhat higher in Manitoba. This may reflect an anomaly as the rates of suicide among young people in Manitoba doubled in 2005. In real numbers, the number of children who died of all issues in Manitoba and Saskatchewan was relatively equal, with both provinces recording an equal number of suicides (27) and Manitoba recording slightly more homicides during 2003-2004.

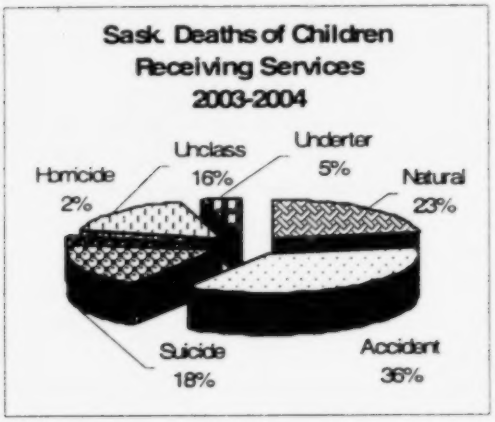
Figure 6: Comparison of Deaths of All Children in Manitoba and Saskatchewan

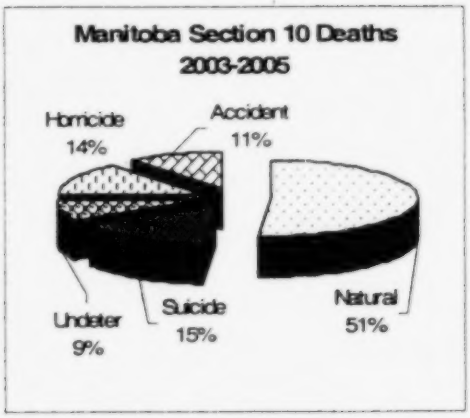


An unexpected pattern emerged when looking at deaths of children known to the child welfare system in Manitoba and in Saskatchewan. While most homicide and suicide victims in Manitoba were known to the child welfare system prior to their death, relatively few children in Saskatchewan were receiving or had received child welfare services six months prior to death. For example, of the eight homicides against children in Saskatchewan during 2003-2004, only one child was receiving child welfare services as compared to Manitoba, where 19 of the 24 homicide victims were known to the child welfare system. This may be because Manitoba reviews the deaths of children who received services up to a year prior to the death, while Saskatchewan only records deaths up to six months prior to the death. There may be other differences between the provinces in child welfare policies, procedures and information gathering. Figure 7 provides more details on causes of death.

[23] While Saskatchewan figures for 2005 were not available at the time this report being compiled, it is our understanding that there was very little difference from the 2004 statistics.

Figure 7: Comparison of Deaths of Children Receiving Child Welfare Services in Manitoba and Saskatchewan





In this short overview, some of the themes noted in the deaths of children in Manitoba and Saskatchewan were explored. This overview only provides statistical information regarding the manner of death and does not fully answer questions related to the conditions in which each of these children lived and died.

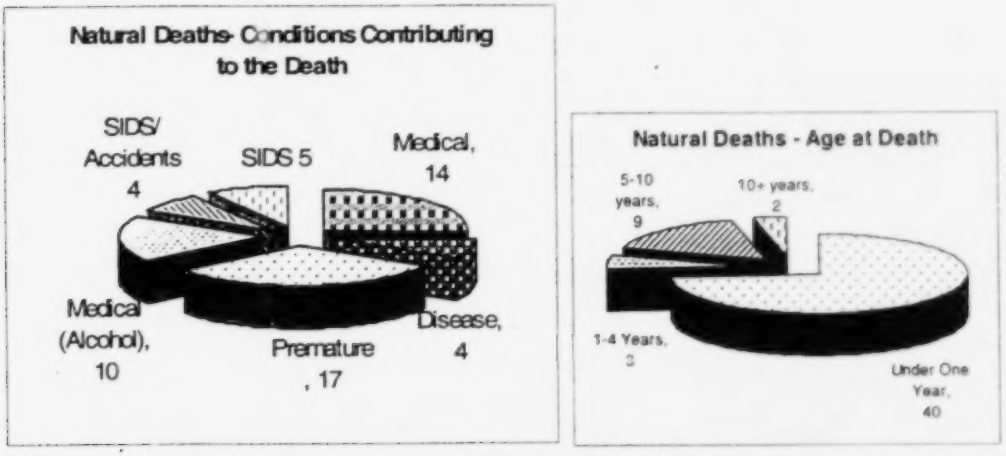
To better understand what happened, interviews with collaterals and documents collected through various sources were used in an attempt to draw a picture of how the children in the study lived and died with respect to what might have reduced the risk of death of that child and what services need to be in place to further reduce the risk of death of this type throughout the province. This material follows in this report.

4.0 Deaths from Natural Causes

Over the length of the study, about half or 75 of the children died of 'natural' causes. This included a group of premature children, children who died in their cribs, children who died as a result of complex medical needs and children who died as a result of an acquired illness or disease.

This study examined 54[24] of the 75 deaths that were ruled by the CME as 'natural deaths.[25] The vast majority of these deaths were connected to medical conditions related to birth abnormalities, SIDS and premature birth. About 73% of children in the study died in the first year of their life as a result of these conditions. Of particular note, was the number of children born with medical conditions related to prenatal alcohol use. Figure 8 outlines some of the issues contributing to the death of these children.

Figure 8: Deaths of Natural Causes: Cause of Death and Age of Death

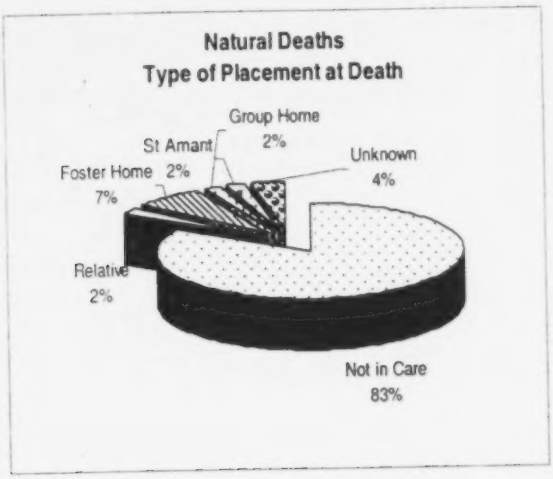


The review noted that relatively few of these children, six in total, were in the care of a child welfare agency at the time of their death. In fact, 11 families who had children die in this group had been identified as 'high risk' by the agency who had released a 'birth alert' before the birth of the child in question. In almost all of these cases, the birth alert was as a result of problems with addictions. Figure 9 outlines the type of placement that children were in at the time of their death

[24] The study only reviewed deaths of children that had a completed Section 10 report from the CME's office.

[25] Two other natural deaths were included in the files sent to the study from the CME's office. Both of these were unremarkable deaths related to a premature birth. However, both had very tentative CFS involvement and the issues presented were seen to be too far removed for consideration in this review.

Figure 9: Deaths of Natural Causes: Type of Placement



Within the group of deaths by natural causes, three additional themes emerged. They are: a) the use of Voluntary Placement Agreements, b) issues with prenatal alcohol abuse, and c) the incidence of Sudden (Unexpected) Infant Death Syndrome (SIDS/SUDS).

4.1 Voluntary Placement Agreements Related to Complex Medical Needs

In the review, seven children were living in an alternative placement at the time of their death; five in foster homes, one in a group home and an additional child living at a facility for children with severe disabilities. In many cases, the parents of these children had signed a Voluntary Placement Agreement (VPA) in order to get the help needed to support their children with complex medical or physical needs and/or to facilitate a referral to an institutional placement.[26] This practice was especially prominent within rural and Northern First Nation agencies that do not have the same level of access to medical supports.

[26] In its 2005 report, Fuchs et al also noted how frequently children with disabilities supported by the child welfare system under a VPA agreement. Page 69 of that report suggests that the VPA provision for disability is not being used generally to maintain the connection between parents and children with disabilities and more work needed to be done to provide a higher level of parental involvement in the lives of children with disabilities in care under a VPA arrangement.

The use of VPAs to support children with complex medical needs is a practice noted in Section 14 of *The Child and Family Services Act*. Section 14 (1) states in part:

> "14(1) An agency may enter into an agreement with a parent, guardian or other person who has actual care and control of a child, for the placing of the child without transfer of guardianship in any place which provides child care where that person is unable to make adequate provision for the care of that child
>
> (a) because of illness, misfortune, or other circumstances likely to be of a temporary duration; or
>
> (i) is a child with a mental disability as defined in *The Vulnerable Persons Living with a Mental Disability Act*, or
>
> (ii) is suffering from a chronic medical disability requiring treatment which cannot be provided if the child remains at home."

It appears that the practice of using Child and Family Services to access supports for children with complex medical needs is related, in part, to accessing funding for these services. It was noted that facilities such as the St. Amant Centre and the Manitoba Developmental Centre require a family to sign a VPA in order to access their services, in order to access the funding necessary to support that child. Once again, this policy seems to have begun as a way of supporting families who had children with complex disabilities.

Two cases stand out in this area. In one case, an adoptive family was asked to sign a VPA for their child in order to access a bed at a health facility for their dying child. The family had explored other options and had concluded that the facility was the best placement for their child. In another case, Children's Special Services asked Winnipeg Child and Family Services to intervene to facilitate a referral to the same facility for a dying child against this family's wishes. The parents indicated that they wanted their terminally ill child to be cared for at home with the support of Children's Special Services. Children's Special Services, in turn, indicated that the cost of providing 'in home' services to the child was cost prohibitive and exceeded their budget for this type of support, thus a placement in the facility would be a more cost-effective setting for this child. Child and Family Services declined to become involved in the case and the child remained in the home until his death.

It could be argued that families who have children with complex medical needs ought to have the opportunity to decide the type of services they prefer for their child and their family. In some cases, that might include the involvement of child welfare as a form of support for the family. In other cases, this might include the use of family service funding to maintain the child in the home. In either case, it seems that the practice of bringing children into care to access services may be difficult for families who may not want the stigma of having to put their children 'in care' in order to receive the services they need for their child and family.

While it would be difficult to determine if overcoming issues related to funding and jurisdiction would have prolonged any of these children's lives, it certainly would have improved the quality of life for the child and family.

Recommendation #3

That the Province of Manitoba develop a more effective method of supporting children with complex medical needs that does not require their family to sign Voluntary Placement Agreements (VPAs) as a condition of receiving appropriate services.

Recommendation #4

That the four Authorities develop a sub-committee on medically complex children that will develop policies and practices regarding best methods of supporting these children within the child welfare system.

4.2 Prenatal Alcohol Use

As reported earlier, 10 of the children identified as dying of natural causes died as a direct result of prenatal alcohol use. In many other cases, prenatal alcohol use was a strong contributing factor in the child's death. In fact, two-thirds of the cases in the study cite alcohol and drug addiction as the presenting issue in their involvement with CFS. Most of these children were known to the agency to be at very high risk for birth defects as a result of parental addictions to alcohol and/or drugs as the mothers were known to be drinking and/or using drugs heavily through their pregnancy and/or already had given birth to children suspected of being affected by Fetal Alcohol Spectrum Disorder (FASD).

Research shows that Fetal Alcohol Syndrome is the leading cause of intellectual disabilities in Canada.[27] Children born with FASD are more fragile at birth and exhibit life-long disabilities that will affect every part of their life. Unfortunately, most of these children come from very high-risk situations and many have complex medical and social needs that put additional financial pressures on the medical and social services system. The fact that parental addiction was a contributing factor in the death of so many of these children is startling and suggests a need for a far more proactive approach in supporting high-risk mothers to help them reduce their level of alcohol consumption throughout their pregnancy and afterwards.

Manitoba has become a Canadian leader in the development of FASD prevention services for high-risk women. In 1996, Winnipeg Child and Family Services attempted to put the question of the role of child welfare authorities in ensuring the safety of the fetus before the courts by requesting an order for in-house treatment for a young woman known to be an active glue sniffer who was pregnant with her fourth child.[28] While the courts ultimately ruled against the request, the issue continued to be debated by interested parties who agreed with the literature that suggested that support to mother is more effective than forced treatment or incarceration. This spirit is captured by a midwife saying, "Mother the mother and she will mother the child".

In 1998, 'STOP FAS' programs were introduced in three communities; two in Winnipeg and one in Norway House. They were designed to provide mentor support for pregnant addicted mothers who wanted support in reducing their alcohol consumption while pregnant.[29] The program has since expanded to two additional sites in the North as a result of encouraging outcomes. Further, under First Nations and Inuit Health Branch, Health Canada has introduced similar types of support programs for pregnant, addicted women in several First Nation communities.

Along with the STOP FAS program, a number of agencies have developed prevention programs for addicted women who access their services. Winnipeg Child and Family Services Perinatal program, for example, provides support to pregnant youth who are under the age of majority. Young pregnant women are referred to the program and agency staff work closely with the young woman to develop a treatment plan for mother and baby. The program has been operating for many years and has developed some credibility with young women in the community. However, the program is only available to young women under 18 who are having their first baby. Given the fact that many of the mothers in this study were between 18 to 25 years of age, it seems reasonable to expand this program to include self referrals from 'high risk' women aged 18 to 25 years.

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[27] Chudley, A (1991). Fetal Alcohol Syndrome: A Preventable Cause of Birth Defects and Mental Retardation. *Manitoba Medicine 61(2)*. Pgs. 53-56.

[28] The Women's Health Clinic web site (www.womenshealthclinic.org) has an excellent overview of issues related to the 'G' case.

[29] See Umlah, C. & T. Grant (2003). Intervening to Prevent Prenatal Alcohol and Drug Exposure: The Manitoba Experience in Replicating a Paraprofessional Model. *Envision, The Manitoba Journal of Child Welfare* 2(1), pgs 1-12. for further information about these programs.

Outcome reports from the STOP FAS programs suggest that, when used, the success rate of reducing the births of children born with FASD is up to 64%.[30] While it is not possible to predict exactly how many deaths and child health problems would be prevented by improved programs for mothers with alcohol and drug problems, a mother's access to and involvement in a STOP FAS program, is likely to play a strong role in prevention. Unfortunately, similar programs are not available in some of the highest risk communities in Manitoba due to funding constraints and a lack of qualified staff. Funding to make these programs more available would help reduce unnecessary deaths and disabilities.

Recommendation #5

That the STOP FAS program be expanded to include sites in the highest risk communities in Manitoba and that it be made available to expectant 'high-risk' mothers between the ages of 18 to 25 years of age, on self-referral.

Recommendation #6

That a provincial FASD prevention and intervention committee be established to develop innovative ways that child welfare agencies might employ better support to high-risk mothers to reduce the alcohol and drug problems in young people likely to become parents.

Recommendation #7

That where existing perinatal programs or services are available, the mandate be expanded to include voluntary referrals from women aged 18 to 25.

4.3 Deaths in Cribs

In the past, deaths of children who died unexpectedly in their sleep were termed as 'crib death' or Sudden Infant Death Syndrome (SIDS). Current technological advances have helped the medical profession pinpoint the exact cause of some of these deaths which, in turn, has lowered the number of 'unexplained' deaths. As well, educational campaigns advocating safer sleeping environments for babies have reduced the number of children who died in their cribs overall. In fact, the incidence of SIDS has declined 50% over the past 10 years partially as a result of better diagnostic tools and increased public education. In Manitoba, the rate of death due to SIDS has declined from 24 deaths in 1990 to 2 deaths in 2003.[31] However, according to National statistics, SIDS remains the second-leading cause of death in children under one year of age, second only to congenital anomalies.

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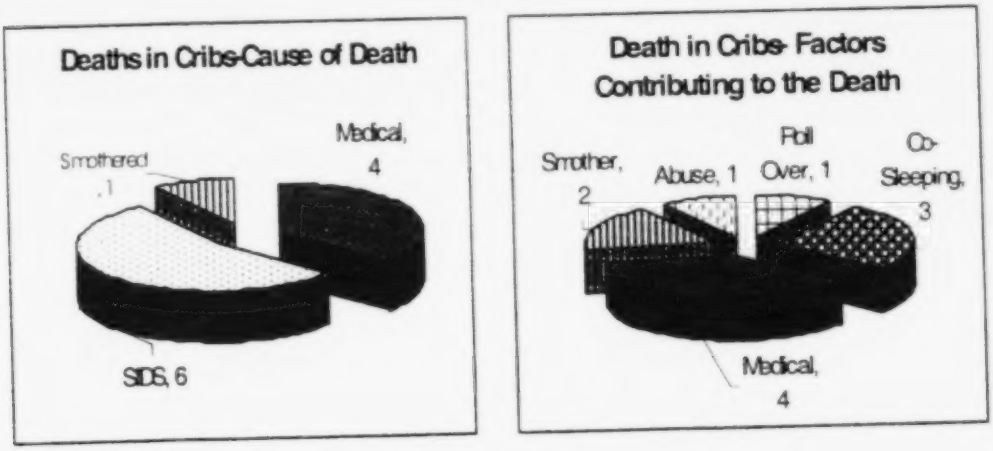
[30] Statistics provided by Michelle Dubick, Healthy Child Manitoba.
[31] Statistics taken from the 2003 Annual Report of the Chief Medical Examiner, pg. 13.

The study reviewed 13 cases of children who died unexpectedly in their sleep. Eight of these deaths were attributed to 'Natural or Undetermined' as the primary cause of death with SIDS as a 'significant condition contributing to the death,' and others attributed to other physiological conditions or accidents. All were under 13 months old, had died at home and had been found in their crib or bed. None of the children were in care and all had been living with their families at the time of the child's death. However, all had been involved with the child welfare system, and all but one had been deemed a high-risk family by that agency. Figure 10 provides further information gleaned from the reports from the CME's office.

Figure 10: Deaths in Cribs



We were concerned to note that 70% of the children in this group were born to mothers with addiction problems. All but one of these mothers were drinking and/or using drugs at the time of the death, with four children dying as a result of co-sleeping with an intoxicated adult.

While the cause of all unexpected deaths has never been fully understood, evidence suggests that the cause of death is generally a combination of medical and environmental factors.[32] Co-sleeping with babies has also been shown to be a risk factor. The risk increases substantially when the adults are under the influence of alcohol and drugs when sleeping with their baby.

[32] Hunt, C. & F. Hauck (2006) Sudden infant death syndrome. *Canadian Medical Association Journal, 174* (13), 1861-1869.

Willinger (1991) suggests that maternal drinking is also a risk factor for SIDS, especially if drinking occurs in the three months prior to conception and during the first trimester or the drinking patterns include a high level of binge drinking (drinking more than four drinks at a sitting).[33] Studies have also shown a very high correlation between a baby's exposure to tobacco smoke during pregnancy and/or exposure to second-hand smoke and SIDS. All of these concerns have been voiced in a joint statement by the Canadian Foundation for the Study of Infant Deaths, the Canadian Institute of Child Health and the Canadian Paediatric Society (2004) who recommend that infants be cared for in a smoke and drug-free environment.[34]

It was also noted that seven of the children in the study had been found by their parents either face down or on their side. In two of the cases, the children appeared to have been smothered by their bedclothes. Placing babies on their sides or stomachs has been found to be a risk factor for SIDS, and most health care providers now recommend that babies be placed on their backs to sleep unless instructed differently by their family doctor.

The Review Team considered ways to increase the dissemination of materials designed to prevent SIDS. A recent short video on "Shaken Baby," available through Healthy Child Manitoba, had been widely distributed and available to professionals and consumers alike. A "Safe Sleep, Sweet Dreams" baby blanket is available for purchase through the Internet that provided pictorial information regarding risk factors associated with SIDS.[35] Both of these promotional materials are innovative methods of providing important information to families that might not have access to written materials. It would seem reasonable to ensure that this type of information be made readily available to parents in a public service ad, video or other format that could be distributed to hospitals, health clinics and/or family centres in Manitoba

Recommendation #8

That Healthy Child Manitoba develop and distribute information regarding reducing the dangers of SIDS/SUDS to Healthy Baby sites, health clinics and hospitals throughout Manitoba.

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[33] Willinger M., James LS, Catz C. (1991) Defining the sudden infant death syndrome (SIDS): deliberations of an expert panel convened by the National Institute of Child Health and Human Development. *Pediatric Pathology 11*, 677-684

[34] Joint statement from the Canadian Foundation for the Study of Infant Deaths, the Canadian Institute of Child Health and the Canadian Paediatric Society (1999) *Paediatrics and Child Health (3)*, pgs. 223-4. Downloaded from www.cps.com on June 13, 2006.

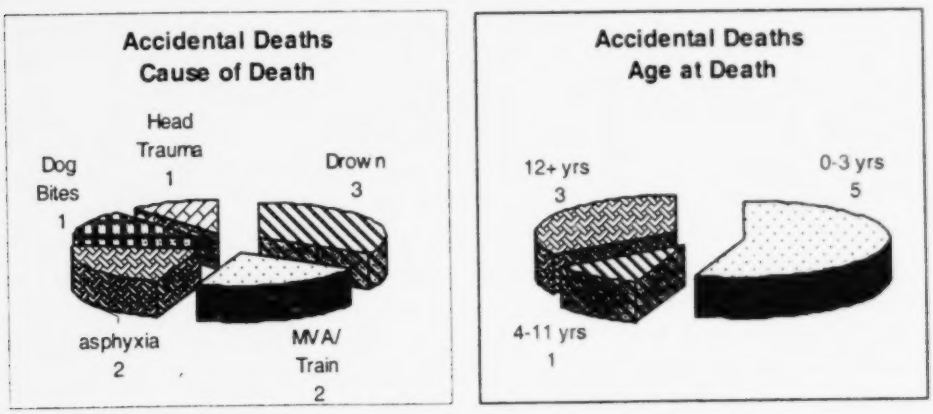
[35] The 'Safe Sleep Sweet Dreams' blanket is available at www.online-clinic.com.

5.0 Accidental Deaths

Nine children in this study died as a result of accidents. With the exception of children who drowned, each accident was unique and there appeared to be no one common issue that influenced or could have prevented the death of that child. First Nation and Northern communities were slightly more represented among accidental deaths. However, there was no similar cause or patterns in these deaths that might suggest that children in First Nations communities or the North are at an increased risk for specific types of accidental deaths or that children in First Nation and Northern communities are any less safe than children from other communities in Manitoba.

When considering the age and type of accident, it appeared from this very small sample that while accidents among young children appeared to be related to hazards within the home or community (such as drowning or motor vehicle accidents), youth who were over 12 were more likely to die from putting themselves at risk within the home or community. In cases such as the child who died of asphyxiation related to sexual activities, accidents may have been prevented had the youth had a better idea of the dangers of the activity they were engaged in. Figure 11 provides more detail concerning accidental deaths.

Figure 11: Accidental Deaths: Manner and Age at Death



5.1 Water/Bathtub Safety

In reviewing the cases of accidental deaths, the Review Team noted that the study included three drowning deaths. Two babies in this study drowned in their home bathtub. Therefore, it is fitting to make recommendations regarding water safety, particularly for babies and very young children.

The recent inquest into the death of a two-year-old child who drowned in a hot tub while in a foster home demonstrates the speed to which a toddler can accidentally fall and drown when not supervised at all times. A report from the Children's Hospital in Winnipeg reports that drowning is a major cause of accidental child deaths in Manitoba and that toddlers tend to drown by falling into various collections of water found in and around the home. The report notes that two-thirds of these deaths occurred when the child was alone and unsupervised. Finally, the report also shows that for every child that drowns, another child has experienced a 'near' drowning that may have left them with various degrees of permanent brain damage.[36]

The Snowdon Inquest made a number of recommendations in regard to reducing the drowning risk for children in foster homes. Many of these recommendations relate to increased training in the area of water safety for social workers and foster parents. Of concern, however, was the fact that the inquest was silent on the issue of who would assume the costs of providing this training to foster care workers, foster parents and foster children. The Review Team recommended that if it is determined that training in this area will be undertaken by agency staff and/or foster parents, that the costs of training should be borne by the Child Protection Branch and not individuals.

Recommendation #9

That the Child Protection Branch, in consultation with the four Authorities, in reviewing the recommendations from the Snowdon Inquest, ensure that foster parents/ alternate care givers whose residence contains a pool, hot tub, or is in close proximity to a body of water, be required to receive water safety training. Further, the cost of this training would be borne by the Child Protection Branch rather than the caregivers.

5.2 Use of Child Safety Devices

The past twenty years has seen a tremendous growth in the development of safety equipment such as cribs, car seats and strollers have served to minimize accidental deaths among babies and young children. The Canadian Safety Council (CSA) sets out minimum standards in the development of these devices and, in the case of car seats, *The Highway Traffic Act* regulates their use. Within the child welfare system, the use of CSA approved safety devices is a foundational standard for all babies and children in the care of the agency.

All government-approved safety devices, such as car seats, are packaged with warnings regarding the safe use of these devices. All equipment clearly warns against using or altering this equipment in any manner other than what it was designed for.

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[36] Undated report entitled: *Preventing Drowning in Manitoba: A Review of Best Practices*. Prepared for Manitoba Health by Impact: the Injury Prevention Centre of Children's Hospital.

During the review, the team was told of situations in which safety devices were used in a manner in which they were not intended. This included putting babies to sleep in car seats, using car seats and/or cribs as temporary restraining devices and leaving babies unsupervised in bathing 'rings'. In at least one case, a safety device was altered to better contain an active foster child.

The use of 'restraining devices' is covered in Section 433.5 of the 1999 Standards Manual. This standard outlines the type of 'restraining devices' that, with the permission of the child welfare agency, can be used in select situations. Car seats, cribs and other baby equipment is not covered in this policy and, as a result, should not be used or altered to be used for this purpose.

Recommendation #10

That all care providers use only government- approved child safety devices (car seats, cribs, playpens, etc.) in the manner for which they were designed and that they do not make any alterations or modifications to them for any reason.

5.3 The 'Choking Game' and Auto-Erotic Asphyxiation

The 'Choking Game' is a life-threatening activity that has been circulating through adolescent and pre-adolescent culture for many years. Children and youth use their hands, arms, ropes, leashes, chains, ties or belts to cut off their oxygen which leads to a feeling of euphoria when blood rushes back to the brain.

In some cases, youth will employ a similar type of 'choking' when engaging in sexual activities. Although Auto-Erotic Asphyxiation was mentioned as a cause for only one accidental death, the Review Team felt that the danger posed by this dangerous game warranted mention within this study.

Given the danger that either of these pose when and if children are unable to remove the restraints that have constricted their airway, and the fact that death can occur from asphyxiation in a relatively short time, this 'game' has the potential to cause permanent brain damage and even death.[37]

[37] Please see www.teenchokinggame.com for further information about the choking game.

6.0 Suicides

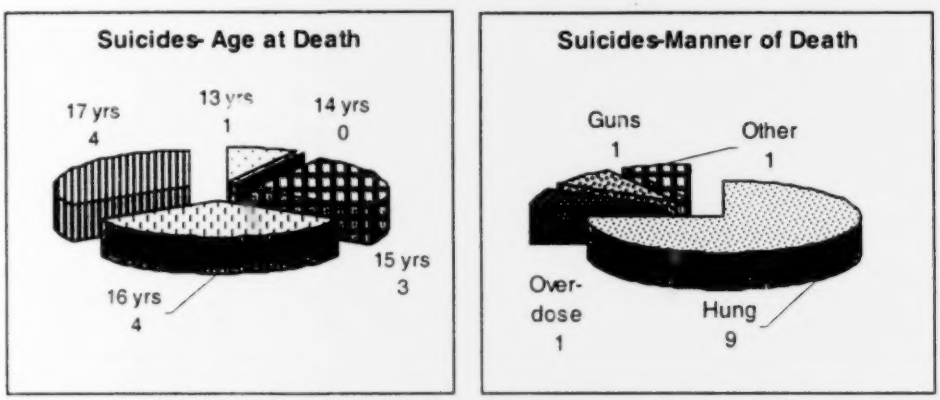
National statistics show that suicide is the second largest killer of youths aged 13 to 17, second only to 'unintentional injuries'.[38] National statistics also show that the incidence of suicide among adolescents has been increasing over the past number of years, particularly among Aboriginal youth.

Twenty-four children receiving services through a child welfare system prior to their death died of suicide in this province from January 2003 to March 2006. All but one of those children were Aboriginal and a disproportionate number of these children were from the North. Sadly, other children have committed suicide since the Review Team began developing this report

Often the lives of children and youth who commit suicide are complex and require a more intense 'Section 10 review' than other types of death. As a result, completed Section 10 reports were available for only half of the 24 deaths by suicide among children and youth known to the child welfare system.[39]

In this time period, most young people who committed suicide were between 16 and 17 years old. The most common method used in completing their suicide was hanging, with only one child dying from a gunshot wound. Figure 11 provides more detail concerning these deaths.

Figure 11 – Number of Deaths by Suicide, Age and Cause of Death



[38] Statistics downloaded from web site: Public Health Agency of Canada.-Canadian Government. Downloaded from http://www.phac-aspc.gc.ca on June 13, 2006.
[39] Please see section 2.1 for a fuller discussion on issues related to missing files.

It is noteworthy that about 60% of those completing suicide were male. On the other hand, national statistics and most research studies show that while girls will attempt suicide more often, boys are three times more likely to die in a suicide attempt.[40] It will be important to see if this apparent increase in the proportion of females who die of suicide is maintained over time. If so, this would have implications in the manner in which suicide prevention programs are developed and offered to children and adolescents.

Another factor of note among the 12 reviewed cases was the high number of children thought to be FASD who committed suicide. Given that one of the common symptoms of FASD is impulsivity and that information from the *Task Force on Suicide in Canada* (1994), suggests that youth suicides tend to be an 'impulsive act', it seems logical that children and youth with FASD would have a higher risk for suicide.[41] Recent research also suggests that youth with FASD have a considerably higher level of mental health problems than their non-disabled peers.[42] This all suggests the need to develop a range of supportive services suitable to the needs of children and youth with FASD. It also suggests the need for increased vigilance about 'child-proofing' homes to ensure that any dangerous materials (guns, medication, etc.) are stored in a manner that reduces the risk for 'impulsive' use.

The review noted that all but one of the youth who died of suicide had grown up in a home with a high level of family violence. In some cases, this violence was the reason that the child had been removed from the family home. Carlson (1984) suggests that domestic violence generally attacks the self esteem of both the parent and the affected children.[43]. Children living in families with a high level of violence often feel a sense of hopelessness and loss, feelings that often lead to an increased risk of suicide.

Finally, the review noted that, while children with other causes of death were most often living in their family home at the time of their death, about half of these children were living in foster care when they committed suicide. Among the youth living in foster placements, most of the suicides took place in their foster home. Most of these youth had lengthy and involved child welfare files, multiple moves and struggles within the foster care system.

Among the youth in this group, a number of patterns or themes emerged. These themes include: a) Suicide in Aboriginal youth, b) Mental Health and Suicide, c) Slashing, Self-

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[40] The Task Force on Suicide in Canada. (1994). Suicide in Canada: *Update of the Report on the Task Force on Suicide in Canada*. Government of Canada:Ministry of National Heath and Welfare.

[41] See Streissguth, A., Kanter, J. (Eds.) *The Challenge of Fetal Alcohol Syndrome: Overcoming Secondary Disabilities*. Washington: University of Washington Press for a further discussion on this theme.

[42] IBID

[43] Carlson, B. E. (1984) Children's observations of inter-parental violence. In A. R. Roberts (ed.), *Battered Women and Their Families*. New York: Springer.

Harm and Attempts Prior to a Completed Suicide, d) Family Violence and Suicide and e) Suicide Prevention Initiatives.

6.1 Suicide Among Aboriginal Youth

Certainly a troubling issue within this portion of the study was the number of Aboriginal youth who had committed suicide. Of the 12 youth suicides in this study, 11 were Aboriginal youth. Further, in at least three of the cases, the suicide of one individual either led to a second suicide[44] by a friend or family member, or came after the suicide of a friend or family member. This 'cluster effect' has been noted in a number of studies related to patterns of suicides in Aboriginal communities[45].

The 1995 Royal Commission Report on Aboriginal People documents that the rate of suicide among Aboriginal people is about three times higher than the national average. However, among youth, Aboriginal children and youth are five to six times more likely to commit suicide than their non-Aboriginal peers.[46]

Most experts in the field suggest that some of the reasons for the high level of suicide among Aboriginal children and youth include cultural stress, socio-economic pressures and disruptive family experiences.[47] Further, while each of these 'stressors' in themselves may not lead directly to young person's decision to end their lives, it is often the combination or 'chaining' of these experiences, partnered with a seemingly small event such as a conflict or a problem within an important relationship, that will lead to a completed suicide.[48] This is a pattern that this study noted as well.

Certainly the effect of the loss of language, culture and a traditional way of life has had a profound effect on the lives of Aboriginal people and communities. The effects of residential schooling on Aboriginal people has affected not only the survivors of these schools but also their children and grandchildren. Children who have grown up in a residential school with no parental influence or normalized family experience may not have the knowledge and skills to be an effective parent. They may, in turn, replicate their own childhood experiences with their children and, as a result, their children can grow up with similar emotional impacts of the residential school experience without fully

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[44] In all of these cases, the second individual mentioned was not part of this study.

[45] See Assembly of First Nations (undated). Acting on What We Know: Preventing Youth Suicide in First Nations: The report on the Advisory Group on Suicide Prevention. Available from the Assembly of First Nations, Ottawa for example.

[46] Chenier, N. (1995). Suicide Among Aboriginal People: Royal Commission Report. Government of Canada:Library of Parliament pg 1-2.

[47] Assembly of First Nations (undated). Acting on What We Know: Preventing Youth Suicide in First Nations: The report on the Advisory Group on Suicide Prevention. Available from the Assembly of First Nations, Ottawa.

[48] Minore, B. & Hopkins, H. (2003). *Suicide Response Plans: A Comparative Cross-Jurisdictional Analysis*. Lakehead University: Centre of Excellence for Children & Adolescents with Special Needs.

understanding the link between their parent's childhood experiences and their feelings of loss.[49]

Chenier documents the effect of 'cultural stress' in the aforementioned Royal Commission Report:[50]

> "Cultural stress is a term used to refer to the loss of confidence of the ways of understanding life and living that have been taught within a particular culture. It comes about when the complex relationships, knowledge, languages, social institutions, beliefs, values and ethical rules that bind a people and give them a collective sense of who they are and where they belong is subjected to change. For Aboriginal people, such things as loss of land and control over the living conditions, suppression of belief system and spirituality, weakening of social and political institutions and racial discrimination have seriously damaged their confidence and thus predisposed them to suicide, self-injury and other self-destructive behaviours." (pgs 2-3)

Research in the field of suicide among children in the care of a child welfare agency shows that Aboriginal children and youth in the care of a child welfare agency are at an increased risk for suicide due, in part, to the effects of 'cultural stress' in their lives. Studies have shown an increase in feelings of powerlessness in regards to their separation from their family and community in Aboriginal children and youth in the care of a child welfare agency. Some research suggests that this risk increases when Aboriginal children are placed in non-Native foster homes.[51] Beiser (1984) suggests that these conflicting values often lead to what he terms a "flower of two soils."[52]

Certainly it is outside of the scope of this review to make comments about child welfare practice as it relates to the placement of Aboriginal children in non-Native homes. It is the review's understanding that these issues have been reviewed in the past and formed one of the founding elements of the Aboriginal Justice Inquiry-Child Welfare Initiative. However, the review did suggest that more work needs to be done to deal with the worrisome problem of suicide among Aboriginal youth receiving services from the child welfare system.

Recommendation #11

That suicide prevention materials be developed which include both culturally sensitive content and which emphasize the development of healthy social connections and

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[49] Please see Wesley-Esquimaux & Smoleski (2004). Historic Trauma and Aboriginal Healing. Ottawa: Aboriginal Healing Foundation for a fuller discussion of this theme.

[50] Chenier (1995).

[51] Please see Richard, K. (2004). A commentary Against Aboriginal to non Aboriginal Adoption. First Peoples Child and Family Review 1 (1), pgs 101-109. for further discussion on this theme.

[52] Beiser (1984) as cited in The Task for on Suicide in Canada. (1994). Suicide in Canada: *Update of the Report on the Task Force on Suicide in Canada*. Government of Canada:Ministry of National Heath and Welfare. Pg. 24.

healthy self-esteem. This may be achieved through a collaborative relationship with Manitoba Health, Manitoba Family Services and Housing, Manitoba Education and the First Nations Inuit Health Branch.

6.2 Suicide and the Quality of Peer Relationships

A recent study by Bearman and Udry[53] suggests that adolescent girls who are isolated from peers or who have troubled social relationships are more likely to commit suicide than those who have stronger social networks.

Children who grow up in foster care may experience many moves throughout their time 'in care'. In many cases, children and youth must develop a new 'circle of friends' after each move. Making relationships can be difficult if the child is struggling through school, has behavioural and/or learning struggles in the classroom and/or is no longer in school. In these cases, youth may find it easier to form social connections in environments that are less stressful or in areas which they feel accomplished or successful. This may include social clubs, church activities, sports teams or skill enhancing programs.

It is unfortunate that little attention is paid to exploring a child's social network when developing case plans for children. It appears that too often, case plans document troubling or problematic and/or sexual relationships but not the quality of healthy or supportive peer relationships. As a result, in reading each child's Section 10 report, it was hard to ascertain the extent that peer relationships was a factor in the life and death of the youth. However, given the importance of this issue, it makes sense to increase the opportunities for both young women and men to increase healthy social connections as a strategy to promote positive mental health and reduce the risk of suicide.

Recommendations regarding increased funding for recreational and skill-building activities for children in and out of care have been included in the section on gang violence. The review strongly recommends that funding in this area be increased to improve the quality of life and reduce deaths of children and youth at risk for suicide in Manitoba.

6.3 Mental Health, Self-Harm and Suicide

Nine of the 12 adolescents, who committed suicide, had a history of depression with eight of the nine assessed by a physician shortly before their death. In at least three cases, the youth was seen as 'not a risk to self' by the attending doctor when the youth was taken to the local hospital. These young people committed suicide shortly after their visit to the hospital. In many cases, the trip to the hospital was the first time that these children had shared their feelings and allowed themselves to be seen by a medical professional.

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[53] Reference to this study was found on ww://www.unc.edu/news/archives/jan04.html

Without additional information related to the young person's mental status, personality, mood and general health, it would be difficult to tell how they presented in these assessment situations. Given the stigma against suicide and mental health that exists in our society and the fact that adolescents may not want to be 'labeled' as being mentally ill, under-reporting can be a risk in these situations.

The Review Team noted that previous protocols related to visits to the emergency department of a hospital with symptoms of depression or self harm is to assess the situation as to acuity, and refer that child or adolescent to an in-patient setting to assure the safety of the child or an 'out-patient' community based support for ongoing treatment. The review noted that this protocol is not being universally applied. The review suggested that many of the young people went away after an assessment without any arrangements for prompt follow-up assessments and treatment.

It is also important to recognize that children and particularly adolescents in the care of an agency may attend to the hospital with signs of distress without informing their parent or guardian (foster parent, group home staff) and, if a child is in care, their legal guardian (CFS case manager). In these cases, the child welfare system may not be aware of the visit until after the child has either made another attempt or a completed suicide. This was noted as a special concern when children are seen by hospital staff over a weekend. The team felt that it would be very helpful if, after a child is assessed in a hospital setting, that the physician or designate inform the local child welfare 'after-hour' service of the child or youth's visit and request an immediate follow-up by an appropriate agency or worker.

Provisions for informing the local child welfare agency of the visit of a youth with suicidal thoughts can be found in section 17(2) of *The Child and Family Services Act*. This portion of *The Act* reads:

> "17(2) Without restricting the generality of subsection (1), a child is in need of protection where the child
>
> (a) is without adequate care, supervision or control;
>
> (b) is in the care, custody, control or charge of a person
>
> (i) who is unable or unwilling to provide adequate care, supervision or control of the child, or
>
> (ii) whose conduct endangers or might endanger the life, health or emotional well-being of the child, or
>
> (iii) who neglects or refuses to provide or obtain proper medical or other remedial care or treatment necessary for the health or well-being of the child or who refuses to permit such care or treatment to be provided to the child when the care or treatment is recommended by a duly qualified medical practitioner;"

Finally, because children in the care of a child welfare agency appear to be particularly 'at risk' for depression, for suicide and self-harm, the Review Team felt that it was incumbent on child protection workers to follow up every suspected case in which a child on their caseload either expresses feelings of hopelessness or depression and/or verbalized a desire to commit suicide regardless of whether the child recants or worker feels the comments will not lead to an attempt at suicide. All of these children and youth should be provided with a community-based assessment as soon as possible and if treatment is required, it should continue for a reasonable period until there is sustained improvement in the young person's condition.

Concerns and actions in these areas should be clearly documented in the young person's medical records and important people such as foster parents, health care staff, and others should be informed of the young person's status and progress.

Self-Harm

The review also noted the high number of children and youth that completed their suicide that had a previous history of self harm, cutting or self-abuse. Five of the youth in this group had a history of 'cutting' previous to their completed suicide. However, as it appears from the reports and interviews, the youths' cutting was not seen as life-threatening but a sign of anxiety, depression or anger.

Self-mutilation has been defined by Levenkron (1998)[54] as:

- Recurrent cutting or burning of one's skin
- A sense of tension present immediately before the act is committed
- Relaxation, gratification, pleasant feelings and numbness experienced concomitant with the physical pain.
- A sense of shame and fear of social stigma, causing the individual to attempt to hide scars, blood or other evidence of the acts of self-harm.

In much of the literature, self-mutilation is not seen as a pre-curser to completed suicide but rather as a way of expressing emotions such as anger, frustration and emotional pain, or as a way of attempting to cope with these emotions. In some cases, cutting can be a way of seeking attention or imitating some other person who has been engaged in similar behavior. Cutting is clearly an indication of distress and difficulty in adjustment and is a problem that warrants attention and appropriate management on its own. This type of adjustment difficulty may be a warning sign of more serious problems to come.

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[54] Levenkron, S. (1998). *Cutting, Understanding and Overcoming Self-Mutilation.* New York: W.W. Norton and Company

The review strongly recommends that all children who show signs of self-mutilation, cutting, etc. be seen by a mental health professional as soon as the behaviour begins. These problems are clear signs of significant adjustment problems. Early intervention with these problems may decrease the likelihood of more serious problems in the future.

Recommendation #12

That the Department of Health work with the Regional Health Authorities to draft a protocol for assessing and treating children and adolescents who come into hospital emergency rooms with feelings of depression, self-harm or suicide. These protocols should include an assessment protocol, a protocol for ensuring follow-up services are offered and a protocol for immediately informing the local child welfare agency if the safety of that child is in question.

Recommendation #13

That child welfare case managers follow-up all reports of suicidal thoughts, actions and/or self-harm behaviours among children receiving services from child welfare agencies by performing an initial assessment themselves and, if required, arrange an assessment by a mental health professional as soon as possible. Based on the assessment of the case manager and the mental health professional, arrangements would be made for prompt follow-up with an appropriate treatment plan that fits the young person's difficulties and life situation.

Recommendation #14

That all reports or disclosures of suicidal ideation or attempts be assessed by a mental health professional with a follow-up appointment within 30 days of the first assessment.

6.4 Evaluating Suicide Risk

The suicide of a child or youth is one of the most distressing situations that a parent or professional may have to experience. These deaths are seen as most difficult because they not only signal the tremendous pain that the child was facing but also the fact that those closest to that person were not able to help the youth or prevent this tragic outcome. In many ways it is also a death that is seen by most as preventable.

When conducting this review, the team was struck by the lack of knowledge regarding signs of suicidal intent, depression and emotional distress among the child welfare workers that we interviewed. While many found the suicide of their client especially painful, many reported that they did not think that the child was in danger before the act. The review believes a system should be developed to ensure that the staff from the Authorities receive adequate training to identify signs of serious problems in adjustment

and risk of suicide, and that approaches are recommended in dealing with these problems. This should be done during pre-service training and again on a regular basis while working in the field.

Recommendation #15

That in pre-service training, child welfare staff receive specific training on identification of young people with significant adjustment problems, emotional distress and risk of suicide. This training should include information about appropriate resources for intervention. The routine use of this information should be evaluated as part of the normal supervision process and regular updates on this training should be provided.

Recommendation #16

That the Departments of Health, Justice, Family Services and Housing and Healthy Living conduct a separate and comprehensive review of all youth suicides in Manitoba during the past five years and that a report be available by June 2007.

Maintaining a Safe Environment

The Task Force on Suicide in Canada reports that suicides among youth are often more impulsive than those completed by adults. In his American study, Shaffer (1988)[55] comments that in these cases, the availability of firearms was an important factor in the impulsive decision of some youth to end their lives. It is important, therefore, to consider not only the relationship between the access to guns in the home as well as access to other hazards that can be used in a suicide attempt.

The Canadian Firearms Act and Section C-46 of the Criminal Code sets out specific guidelines related to the safe storage of firearms. Under these guidelines, all firearms are to be stored unloaded, unable to be fired by using a secure locking device and kept in a locked and secure vault or storage closet. Under the act, bullets are also to be stored in a safe and locked space separate from the space that the gun is occupying.

The Child and Family Services Act/Foster Home Licensing Regulations also sets out procedures as it relates to the safe storage of medication and poisons. It reads:

> Safety and Health practices
>
> 34 A licensee shall ensure that

[55] Shaffer, D (1988). The epidemiology of teen suicide: An examination of risk factors. *Journal of Clinical Psychiatry, 49* (9, Supplemental), pgs 36-41.

(a) all poisonous or inflammable substances, prescription medications and cleaning supplies are stored in a safe manner and are not readily accessible to foster children.

It is evident that guns are an everyday part of rural and reserve community life and that most gun owners are vigilant about ensuring that guns and other weapons are stored in a manner which prevents children and youth from gaining access to them. It is also recognized that it is difficult to be vigilant about ensuring all medications are locked up at all times in a family foster home. However, extra precautions should be in place regarding potentially hazardous and deadly materials when children and youth, who are known to be a high risk for suicide or behavioural problems, are placed in that home to prevent potential problems from occurring.

Recommendation #17

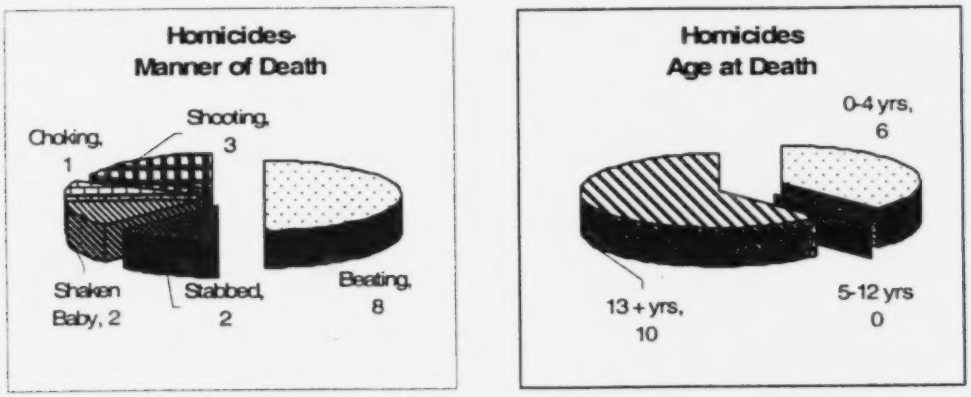
That child welfare agencies ensure that foster homes have adequate information and comply with existing foster home regulations regarding the safe storage of guns, medications and toxic materials.

7.0 Homicides

One of the most distressing group of deaths in this study are the babies, children and youth who died of homicide. These deaths often receive a great deal of public attention and are among the most troubling for the child welfare system. This study examined a total of 18 of homicides of children and youth that occurred between January 2003 and March 2006.

Among the homicides in this study, the majority of children and youth died of physical beatings, while firearm deaths claimed the lives of three youth. Among children and youth who died of homicides, about 60% were over the age of 13, with a smaller group under the age of 5. About 80% of the children who died of homicide were Aboriginal and about 20% were children and youth from Northern communities.

Figure 12: Homicides: Manner and Age at Death



With respect to the manner of death, children under four were most likely to be killed by their caregiver. In most cases, this was the parent or step-parent and, in one instance, the child died in a relative foster home placement.[56] In contrast, the older children were generally killed by people outside of the family. This pattern has also been noted in national statistics of homicides of children and youth.

A number of patterns and concerns arose from the review of homicides among children and youth in this study. They include the use of risk and safety assessments and the need for strategies to deal with gang and street-related activities in youth.

[56] A number of research studies have pointed to the vulnerability of preschool children to fatal injuries and death by their parents. See Kunz, J. & S. Bahr (1996). A profile of parental homicide among children. Journal of Family Violence 11(4), pgs. 347-362 for further discussion on this theme.

7.1 Risk and Safety Assessments

Within the group of homicides explored, 40% of the victims were children under the age of five. All of these children were killed by a parent or caregiver. More importantly, the team noted that the majority of these children were living in homes with a very high level of risk to the children, but none had received a formal risk and/or safety assessment conducted when they first came into contact with a child welfare agency or when they were moved or returned to their family.

The use of 'risk estimation' and 'safety estimation' tools has long been an area of debate within the child welfare system.[35] These assessments are generally check-lists of issues that have been shown to contribute to increasing the risk of neglect or abuse of children at the time of involvement by the child welfare system and/or possible risks to the family if no intervention plan was put into place. The tools generally provide scales or a numbering system that determines the level of risk to the child or children living in that home or family. In some agencies across Canada and the United States, risk and safety estimates may be used voluntarily to help guide a worker's decision. In other agencies, a formal written 'risk/safety estimate' is a mandatory part of the determination of the provision of child welfare services as established by provincial or state legislation.

Proponents of the use of formalized assessments suggest that a standardized tool provides workers with basic information about factors that have been shown through research to be associated with an increased risk to children. They suggest that an assessment tool will help make better clinical decisions regarding the safety of children and help parents better understand the areas needing improvement in order to provide a safe place for their children.

Opponents of the use of formalized assessments argue that a standardized tool does not measure factors that contribute to the general health and safety of children and families; such factors not easily measured but are understood by the child's worker. They argue that standardized assessments are often subjective as they tend to evaluate issues that are related to poverty and a lack of resources - issues that are often out of the control of parents. They suggest that any estimation system is only good for a very short time after completion and does not take into account extraordinary occurrences that may take place within the family after the assessment is complete. Finally, they suggest that standardized tools remove clinical judgment and context, and forces workers to act in cases that they feel may not need the level of intervention suggested by the risk assessment tool.[57]

In 1993, attempts were made by Reid, Sigurdson, Christian-Wood & Wright to develop a risk assessment tool customized to the Manitoba experience. This tool, called the Manitoba Risk Estimation Scales, garnered mixed reviews by child welfare workers who saw the extensive check-lists to be too time-consuming to be helpful in their day-to-day work. First Nation agencies also found that the check-lists were not culturally sensitive and did not fully appreciate the limits to their work.

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[57] An excellent discussion of this issue can be found in *The Canadian Social Work Review*, Volume 18(1).

Assessing risks to children in family settings is outlined in the current Manitoba Child and Family Services Standards Manual. Section 1.1.1 sets out the requirements for safety assessments during the Intake process.

This section reads in part:

> "Mandatory Safety Assessment - When the identified issues (No. 8) require a response immediately and within 24 hours, the intake worker completes the Safety Assessment within 24 hours from the time the referral is received unless the supervisor approves an extension based on a review of the circumstances in the case. Depending on the agency, the initial worker may carry out the safety assessment, refer it to the appropriate worker to do, or refer it to the supervisor to assign a worker. When the recommended response time is more than 24 hours, the intake worker may complete a safety assessment when he or she has concerns about the safety of a child."

While different types of risk estimation tools are being used in various child welfare agencies, it appears that there is no standard tool being used. It also appears that no tool is being used consistently at intake and/or when new situations come to the attention of a child welfare agency.

The Review Team recognized the limits in any risk or safety estimation system. However, it also recognized that there were situations in which a formalized assessment may have helped the worker make a more informed decision about the appropriate level of involvement with the family. It would also act as a guide to remind workers to pay attention to areas which they may not have seen as 'risks'. This was especially true for children under four who, by virtue of their age, had fewer systems (schools, social clubs, etc.) involved with their day-to-day care. These children were often the most vulnerable to parental pressures and less able to remove themselves from harm's way.[58]

In reviewing current 'risk and safety assessments' from various states, it was noted that Michigan and California both employ a one-page 'family assessment' model that provides scales related to both neglect and abuse of children. Questions asked in each state's assessment were somewhat different and appeared to reflect local child protection concerns[59]. This model seemed to be less time consuming for workers to use and may help provide some guidance on issues requiring attention when making determinations of the level of service to provide to children and families. Staff indicated that the Competency Based Training (CBT) model of risk assessment was also helpful.

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[58] Issues regarding the vulnerability of preschool children has been noted in a number of research studies and is discussed in Kunz, J & S. Bahr (1996). A profile of parental homicide among children. Journal of Family Violence 11(4), pgs. 347-362.

[59] In discussions with Andy Koster, Executive Director of the Children's Aid Society of Brant, it is our understanding that a variation of this model is currently being piloted in Ontario.

Recommendation #18

That the four Authorities meet to develop a brief risk assessment tool or tools that are representative of the needs of the province or various regional areas.

Recommendation #19

That the four Authorities undertake to ensure that formalized risk assessments are conducted for every serviced child under the age of five upon intake, and that these reassessments be redone when the child comes into care, is moved to any new foster home placement or if the child is preparing to return to the natural family.

Child Protection and Abuse Protocals

During its review of information regarding risk assessments, the Review Team was provided with a manual entitled: *Child Protection and Child Abuse Manual: Protocals for Social Workers.* It appears that this manual was developed and distributed by Manitoba Family Services and Housing in 2003. This manual provides detailed information on definitions, indicators, legislation, reporting and investigation of child abuse. It also provides information on ways to support children who are disclosing abuse and examines ways of reducing child abuse in the community.

The material in this manual was found to be a useful resource for child protection workers. The material is clear, concise and easy to understand. More importantly, the manual provides important information for child welfare workers in one convenient place.

To ensure good decisions in the area of child welfare, child welfare workers must have a clear understanding of the law, standards and procedures regarding child abuse. Compiling all of this material into one, accessible format is a useful resource for all workers. As the system has recently experienced an influx of new workers with new mandates, it would be very useful to have this resource redistributed as a resource for new workers.

Recommendation #20

That copies of the booklet 'Child Protection and Child Abuse Manual: Protocols for Social Worker, be distributed to all child welfare workers in Manitoba.

7.2 Gang and Street Violence

The increase in gang involvement among disenfranchised youth has become a serious concern in the province of Manitoba and the child welfare system. Street gangs are defined as groups of individuals who have, as one of its main purposes, the commission of illegal activities for the purpose of material benefit.[60]

In many cases, street gangs are closely linked with outlaw motorcycle gangs that are, in turn, associated with the majority of importation and distribution of illegal drugs in and across Manitoba. Street gang members are often responsible for selling the drugs imported by individuals involved in motorcycle gangs. Struggles by 'gang' organizations over maintaining control over the illegal drug market has been responsible for the growth in gang-related violence over the past few years.[61] The Winnipeg Police Service has listed over 2,000 street gang members on their registry and the number continues to grow each year.

Specialists in the area of street gangs suggest that youth, who are at the highest risk for gang involvement, are those who feel detached from a family environment, have a history of physical and/or sexual abuse and victimization and do not have a feeling of safety or belonging in their home and/or community. At highest risk are children who feel a lack of connection with traditional supports such as family, school, culture and community. These children and youth are more likely to invest themselves in activities with others who feel that same level of alienation from the community.

Children involved with the child welfare system are more vulnerable to involvement in street gangs due to their history of family struggles, multiple foster home placements and difficulties in the school system.

Children who feel a sense of disconnect at home and/or school can often find that sense of 'connection' and build a sense of positive self-esteem through the use of social, recreational and community-based activities with peers with similar interests. A 1999 report from Health Canada writes:

> "School and community networks provide the support and enrichment needed to create safe and nurturing environments. Children who have had the opportunity to participate in a wide variety of activities and programs outside the family are more likely to view themselves as capable human beings".[62]

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[60] Manitoba Department of Justice (undated). Project Gang-Proof: Gangs, A Handbook for Families and Community Members. Available on line at crimeprevention@gov.mb.ca.
[61] Ibid
[62] IBID

Given this information, it seems surprising that the Government of Manitoba continues to reduce funding for recreational and social activities for children in care. Current funding for children's social and recreational activities are woefully inadequate to cover costs associated with social and recreational activities for children in the care of a child welfare agency, activities that presumably help build positive self-esteem and enhanced skills in children and youth. These activities are especially important for children or youth who are struggling in school and home and need an activity that will boost their sense of accomplishment and self-worth. Restricting funding in this area makes little sense given that all of the research developed by Health Canada and the Manitoba Department of Justice points directly to the relationship between increased social and recreational activities and healthy lifestyle choices for high-risk children and youth.

The continued erosion in funding for children's recreational and social activities will have a negative impact on the emotional and social development of children in the care of a child welfare agency and may result in higher numbers of children involving themselves in negative activities such as street gangs, drug and alcohol use and other street activities.

Recommendation #21

That the Department of Family Services and Housing immediately raise the funding for social and recreational activities for children in care from $1.47 a day to $2.00 a day and that the money be held in an agency pool to provide recreational programming, such as camps, lessons and club fees for children in care.

Recommendation #22

That the Department of Family Services and Housing, along with any relevant government departments should make available prevention funding, to support social and recreational programs encouraging healthy alternatives for children and youth receiving services through a child welfare agency. No-cost, family-focused recreational activities should be promoted as healthy alternatives for 'high risk' families.

8.0 Preventing Deaths of Children in Care in Manitoba

Through the first part of this study, (Sections 4-7), issues and concerns related to a particular manner of death were noted, including factors related to suicides, homicides, accidents and natural causes. Also noted were a number of issues and concerns that were common in all manners of death and constituted overall risks for children and youth in Manitoba. These issues included the high proportion of children born with FASD, issues related to parent-teen conflict and issues related to the delivery of mental health services in Manitoba. The team noted that intervention and support in these areas might have helped to reduce some of the risks that Manitoba's children are facing, especially children involved in the child welfare system.

8.1 Mental Health

Perhaps the largest area of concern related to the deaths of youth in this province is the ability of the child welfare system to work collaboratively with the mental health system to ensure a seamless delivery of supports when a child or youth is displaying the symptoms of mental health concerns. To accomplish this, there has to be an effective, good-working relationship between the agencies mental health services and appropriate services to respond to these needs.

The Review Team reviewed numerous deaths of children who had been known to the mental health system prior to their death, but may or may not have received service. These deaths included children who died of suicide, homicide and natural causes. Of particular concern, however, were the children who died of suicide. Of the 13 suicides that had been explored, only one did not have a known history of depression, and about half had been seen by a mental health professional within a year of their suicide.

Perhaps the most distressing of these deaths were the youth who presented at a hospital emergency room with symptoms of depression and suicidal thought and who did not receive additional services because the emergency room doctor did not believe that the youth's symptoms warranted a full mental health assessment. Another youth however, did commit suicide within months of his/her hospital visit.

In researching this area further, the Review Team met with agency staff involved with the child at the time of the death, as well as representatives of child and adolescent mental health services in Winnipeg and Thompson. Finally, the Review Team met with a representative of the Winnipeg Mobile Crisis team, a team that is often called upon when a family or school is concerned about the safety of a child. The Review Team was interested in exploring their thoughts on the current service model for children and youth.

In the 2004 Redhead Inquest, Judge K. Mary Curtis noted that:

> "Mental health service in Manitoba is a hydra-headed creature. A myriad of resources exist within the rubric of "mental health." (pg 51)

In reviewing all of the material provided, it became very clear that the current child and adolescent mental health system is under-resourced and, as a result, unable to meet the needs of an increasing number of children and youth with emerging mental health concerns. While this is a concern throughout the province, problems with access to mental health services are particularly worrisome in rural and remote communities. It appears that few comprehensive mental health services are available for children in these communities.

One of the most pressing needs is the availability of emergency support and in-hospital treatment for children seen to be at danger to themselves, due to depression or suicidal thoughts. It is the Review Team's understanding that the Child and Adolescent Treatment Centre (CATC) in Brandon has been operating as a crisis stabilization unit for at least a year and no longer provides in-patient psychiatric services to children and youth in the Brandon, Westman and Parklands area. It is also the understanding that very limited services are offered at other rural hospitals and that children with acute issues are transported to larger health centres such as Winnipeg.

Shortages in services in the rural area exert pressure on the Winnipeg system and, as a result, Winnipeg's mental health system is running at 'over capacity' levels much of the time. This system is both confusing and difficult for families and child welfare workers who must attempt to meet the emotional and physical needs of the child who may have been transported hundreds of miles to receive services. It also encourages parents and service providers to under-report or minimize concerning behaviours in the child and to try and 'make due' with existing resources in the community.

In speaking of the need for increased 'itinerant' psychiatrists in remote communities, Dr. Keith Hildahl spoke of some of these difficulties when children or families must leave their home community to receive services. The Redhead Inquest recorded his comments as:

> "Another benefit of the itinerant psychiatrist attending a remote community is that people who might not otherwise seek help for fear that they may have to leave the community and their family behind to get that help may be prepared to accept the help they need if they are reassured that they will not be sent away from home." (pg 54)

Additional problems were noted in First Nation communities in which issues related to inter-jurisdictional responsibility[63] create additional confusion and shortages in service. There continues to be some confusion about availability of hospital services for on-reserve children and the conditions under which children and youth are able to access these services. This was also noted in the 2004 Redhead Inquest in which Judge Curtis wrote:

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[63] Please refer to the section 8.3 on Inter-Jurisdictional Issues for further discussion of this theme.

> "Much evidence was given during the course of the inquest that there have been various and sundry attempts to bring together people from different service areas. Discussions take place, but rarely are the people involved in a position to effect change. This is not a new problem. The concept of integration of all levels of leadership and jurisdictional responsibility holders coming together for an integrated model has been written about and spoken in many places including the Royal Commission on Aboriginal Peoples. Failure to integrate these three jurisdictions has negatively impacted on the provision of mental health services, and will continue to do so without the participation of those who are high enough in the scheme of things to take the responsibility of making decisions."

Northern First Nation child welfare agencies reported that the lack of services in the North means their workers are often in the position of providing crisis services for young people with mental health issues without the support of medical professionals, secure crisis facilities and/or follow-up services. The Review Team was also surprised to hear that staff do not have any time off to grieve the death of a child who was in care because there are few back-up supports available to replace them. This creates tremendous stress on their workers leading to a high turnover rate among child welfare staff.

Further, agency staff reported that nurses in First Nation nursing stations may not have specific training in the area of mental health and may rely on 'previous experience' when treating a child or youth with mental health concerns. In many cases, they also may not have access to a physician once the itinerant physician has left the community.

The review was interested in some of the innovations in the field regarding the Manitoba Telehealth system. This service allows community-based professionals to have access to medical professionals as consultants as needed. Community-based workers and patients can have access to this service without leaving the community unless absolutely necessary. The review noted that this may be a program that has real potential to provide a higher level of service in rural and remote communities.

As mental health is one of the primary issues confronting medical staff at nursing stations, it seems that additional professional training in the area of mental health and additional support via a 'Telehealth' system may help to better assess signs of depression and/or suicidal thoughts before these issues become acute.

Recommendation #23

That the Department of Health conduct a review of current child and adolescent mental health services and intervention resources available in rural and remote areas to ensure that children living in these areas do not always have to travel to Winnipeg and Thompson for service.

Recommendation #24

That the Department of Health prioritize the hiring of one or more psychiatrists for the Child and Adolescent Treatment Centre in Brandon to provide full in-hospital and out-patient support for families in the Brandon and surrounding areas.

Recommendation #25

That the Department of Health provide funding to expand the existing training program for Child and Adolescent Mental Health to First Nations staff using Telehealth facilities

Recommendation #26

That the Department of Health provide funding for a mental health Telehealth program based in Winnipeg to improve availability of psychiatry and mental health expertise in rural Manitoba and First Nation communities.

Crisis Stabilization Programs

In many cases, a child exhibiting the signs of depression or suicidal thoughts may not need to be admitted into hospital but may need to be monitored in a secure area for a period of time. The Review Team was pleased to see that the Winnipeg Mobile Crisis Team had begun to work in tandem with the Winnipeg Children's Hospital to ensure that children and youth who had presented at the hospital but did not need to be admitted were offered a 48-hour stay in their crisis stabilization unit instead. This allows the child or youth to have time to think through some of the issues that caused the crisis and ensures that the child's condition does not deteriorate further. In these cases, crisis stabilization programs can be cost-effective and an invaluable resource for families and the child welfare system.

Mobile crisis teams perform an invaluable service in working with families within the child's home or residence to defuse and de-escalate difficulties that the child or youth is experiencing. Mobile crisis staff are able to develop emergency case plans for the child, mediate parent-teen conflicts, assess mental health or possible suicide risks and/or help a child or youth work through issues related to crises in their lives. These units are a cost-effective way of reducing harm and ensuring the safety of children and youth in crisis situations.

In reviewing the services of Macdonald Youth Services' Mobile Crisis program in Winnipeg, the Review Team was made aware of the shortage of crisis stabilization beds available for children and youth in crisis situations. The need is particularly chronic in the female unit which, the Review Team was told, is running at almost 100% capacity. It seems reasonable, therefore, to expand this service to accommodate the needs noted in this program as this is a cost-effective way of ensuring the safety of children in crisis situations.

It was also noted that wait times for service through the Mobile Crisis team is increasing as the service becomes better known. There is a particular need in the early evening when children and youth are out of school and appear to have a higher need for counseling, support and /or mental health services.

At the moment, mobile crisis programs for children and youth are available in various fashion in some regions. It was agreed that if these types of services were developed and/or strengthened, they would be a valuable resource to reduce the number of children at risk of suicide in Manitoba.

Recommendation #27

That the Department of Family Services and Housing provide additional funding for five additional beds in the girl's crisis stabilization unit.

Recommendation # 28

That the Winnipeg Mobile Crisis Team be expanded to include one additional evening staff to accommodate youth in crisis.

Recommendation # 29

That the Department of Family Services and Housing and the Department of Health work in tandem to develop Mobile Crisis teams and Crisis Stabilization programs in all Manitoba regions that do not currently have such a program.

Out-Patient and Community-Based Mental Health Services

Community-based counseling and mental health services have proven to be the least intrusive way of delivering mental health services. This was also noted in the 2004 Redhead Inquest:

> "It is also difficult once somebody has been taken out of the community and "treated" and is to be sent back into the community because: (1) The situation at home in the community is probably no different than it was prior to the young person being sent away for treatment. The result is, of course, that with nothing changed, whatever gains had been made while the person was out of the community are likely quickly undone once they simply go back into the same milieu." (pg. 55)

Despite this, the Review Team noted that public funding for 'out-patient' counseling for children and families remains in short supply in areas outside of larger population centres. Further, the review noted the long waiting lists for publicly funded programs (if available), and difficulty accessing programs.

Funding cuts have also been noted in the out-patient mental health program offered through First Nation and Inuit Health Branch which now caps service at 6 to 10 sessions. These reductions have led to long-waiting lists and reductions in service which, in turn, puts additional pressure on the in-patient hospital programs and only serves to increase the intensity of the presenting issues and has the potential to cause serious harm and/or death in some situations.

It is believed that cuts to publicly-funded counseling programs may provide short-term savings to government but has the potential to create long-term and more intensive hardships for children and families, particularly those with fewer resources.

Recommendation #30

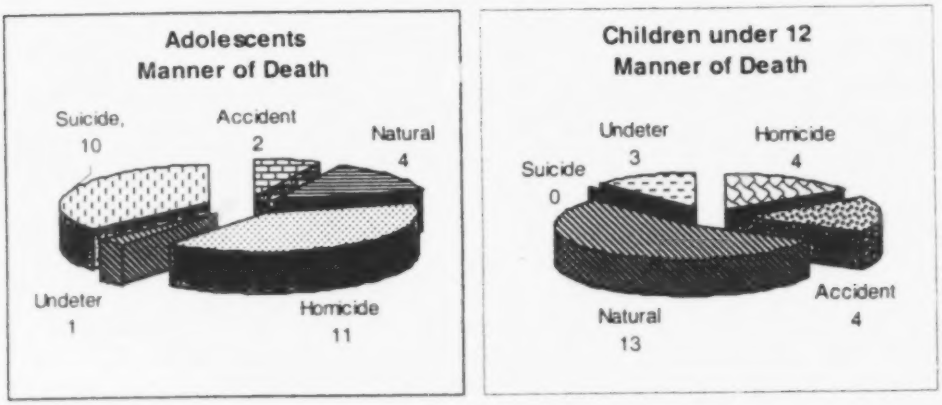
That the Department of Family Services and Housing and the Department of Health expand funding for out-patient treatment services for children, youth and families such that a child, youth or family is able to access counseling within 12 weeks of referral.

8.2 Parent-Teen Conflicts

Perhaps the single largest group in this study was youth over the age of 13. Often times, these deaths were particularly troubling because they signaled problems within the child welfare system, the lack of services for youth and the lack of coordination between services designed to support adolescents. Further, the review found that service delivery from all agencies differed dramatically throughout the province both in philosophy and in availability. This; in turn, led to gaps in services that affected the lives and deaths of these adolescents.

It was interesting to note, within this study, the pattern of death by age category. While younger children tended to die as a result of natural causes, accidents and homicide, adolescents had a greater likelihood of dying from homicide or suicide, with a much smaller number of youth dying as a result of accidents or natural causes. It is also important to note that in almost all of these deaths, including one of the natural deaths,[64] the actions of the youth contributed to their death.

Figure 13: Death of Adolescents and Children-Manner of Death



It was also noteworthy that only a small number of youth in this study were living in the care of an agency at the time of their death. However, those that were in the care of an agency were more likely to have been permanent wards with long-standing issues within their family of origin. In a small number of cases, the adolescent had recently entered care as a result of either a medical condition or issues in the family home that were so intense that the parents were no longer able to support that child. Two main issues were noted in this theme; parent-teen conflicts and specialized services for adolescents.

Parent-Teen Conflicts

While none of the children's demise, to date, have been as a direct result of parent-teen conflict, the Review Team noted that, in at least three of the recorded homicides, in many of the suicide deaths and in one of the natural deaths cited, conflict between the youth and the parent was a contributing factor in the death.

[64] One of the youth in the natural death category died of natural causes that could have been reversed had she followed the strict medical regime that her doctors had ordered.

Parent-teen conflicts are not a new phenomenon. Child development specialist Erik Erikson studied issues related to emerging self-identity beginning in the 1950s[65] and writers have produced 'self-help' books[66] on living with adolescents since then. What has changed, however, is the growth within child welfare agencies of referrals and self-referrals from adolescents citing parent-teen conflicts as their reason for referral. Often these situations can be diverted to mediation between parent and child, and protection services are not necessary. In general, it appeared that agencies were often reluctant to become involved in family disputes unless the adolescent demonstrated extreme needs, some vulnerability within the family or community and/or had no other options. However, in other cases, long-standing and chronic issues in the home were intensified by the onset of adolescence or the issues presented were so intense that mediation is unsuccessful.[67] This may mean that the child must be taken into care to provide the supports he/she needs through his/her adolescent years.

It was found that when adolescents came to the attention of an agency as a result of parent-teen conflicts, services varied widely between agencies throughout the province. A youth may present to an agency by disclosing physical altercations with a parent, and this may be categorized as a 'high needs' case that necessitates the placement of the adolescent. In other cases, the situation would be viewed as a typical parent-teen conflict and the child and family would be forwarded to voluntary community services for follow-up. Too often, this referral was not followed again up by the referral agency to ensure that the child and/or family were receiving the services needed.

In response to the increase in referrals of adolescents, Winnipeg Child and Family Services initiated a Parent-Teen Conflict mechanism at the Intake level. Service providers reported that this service was invaluable for workers as it allowed for a more mediated approach to be taken for families who otherwise would not be involved in the child welfare system. Criticism of the service indicated that adolescents were being referred to mediation without closer examination of the situation within the family. Service providers also reported that the program did not have built-in follow-up services to ensure that issues which necessitated the referral had been resolved and that any necessary services were in place.

The review found that not enough follow-up was being undertaken to assess the source of difficulties when adolescents presented themselves or were referred to a child welfare agency. In some cases, this led the workers to assume that the problem would solve itself and, as a result, they would not do a more complete assessment of the child's emotional or physical concerns.

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[65] Erikson, E. (1968). *Identity, youth and crisis*. New York: Norton Books.

[6666] For example, Wolf, A. (1991). *Get Out of My Life but first could you drive me and Cheryl to the mall-A Parent's Guide to the New Teenager*. HarperCollinsCanada Press.

For example, in one case, a mental health worker had called the agency to indicate that an adolescent may be in danger due to the family's situation. The referral was followed up with a phone call and was categorized as a 'parent difficulty' without directly assessing the family of origin. This child died a few months later and the case remains unsolved. In three other cases, adolescents who had received Child and Family Services in the past, had presented to the agency with disclosure/allegation of in-home abuse and had been categorized as parent-teen conflict with little follow-up.

The review also noted that, despite specific mention in *The Child and Family Services Act*,[68] funding for individual counseling for children and youth not in the care of an agency has been severely reduced in the past few years. Funding to provide ongoing counseling in the case of parent-teen conflicts had also been reduced leading to situations in which a child and family must either find the funding needed to pay for counseling or wait up to six months for publicly-funded services if they were available in their area. The Review Team noted that this service could help determine the extent of difficulties in the home and/or assess the effect of these difficulties on the children in the home. It is strongly recommended that funding in these two areas be restored and be made available in situations where warranted.

While it is difficult to determine if the increased involvement of a child welfare agency would have prevented the death of the child, it is safe to say that more could have been done to protect the child from harm.

Recommendation #31

That once information is received regarding the abuse of a child or adolescent, a complete investigation is conducted to determine the validity of the report regardless of the age of the child.

Recommendation #32

That agencies follow up any referrals made to community agencies within three months after an adolescent and/or their family is referred to ensure that services are being used and that no additional supports are necessary.

Recommendation #33

That the Department of Family Services and Housing increase funding through prevention programs to specifically fund counseling to children and adolescents who are seen to be in high need for support but are not in the care of a child welfare agency.

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[68] Section 7(1) of the Child and Family Services Act sets, as one of the duties of the child welfare system provide family counseling, guidance and other services to families for the 'prevention of circumstances requiring the placement of children in protective care or in treatment programs'.

Recommendation # 34

That the Department of Family Services and Housing increase funding through prevention programs to specifically fund family counseling for parents and adolescents who are experiencing conflict, which has resulted in the involvement of a child welfare agency.

Specialized Services for Adolescents in Care

Service providers reported that finding appropriate services for adolescents was one of the most difficult jobs in the child welfare system. This included finding supports for youth experiencing addictions, mental health or emotional issues and/or disabilities. [69]

Staff interviewed indicated frustration with a lack of specialized placements for adolescents presenting extreme behaviors, severe emotional difficulties and/or street-involved youth. This included specialized foster or group homes, secured short-term facilities in times of crisis and/or long-term institutional placements. Agency staff reported that the waiting list for institutional placements is up to a year, and apart from some very short-term crisis stabilization 'beds', there are no options to protect a child who may need intensive monitoring to ensure that they are not a danger to themselves. Child welfare workers also expressed fear that these kinds of services ended for most children on their 18th birthday, and that they were concerned about their safety once reaching the age of majority. This is especially true in situations in which an emotional or mental health diagnosis had been made or was suspected and/or the child was vulnerable due to a disability such as FASD.

The Review Team also heard from ancillary agencies and services that there was a shortage of emergency supports and beds for youth in crisis. The Review Team noted that calls to the Mobile Crisis Team in Winnipeg have risen dramatically over the last three years and that waiting times for service had been growing in the last few years. The review also noted that there was a special need for increased crisis stabilization beds in Winnipeg for girls who were struggling with issues related to depression or family problems. As a result, teenage girls were not receiving the crisis support needed in a timely fashion. It is strongly recommended that the Province of Manitoba increase funding to crisis services for adolescents to ensure that they receive the services needed in a timely fashion.

In many cases, the Review Team noted strong similarities to the manner in which adolescents died. In many cases, the adolescent had attempted to seek support through the mental health system, schools or child welfare agencies. Support was often not forthcoming due to the lack of availability of services or the inability of these services to properly assess the extent of the need and/or what issues underlay some of the difficulties that the child had reported. It is recognized that adolescents are often reluctant to disclose the full extent of the issues they are facing until they feel safe or listened to.

[69] Sections specific to mental health, addictions and FASD have been discussed in other areas of this report.

The Review Team believes that more specialized supports need to be made available to assist adolescents involved in the child welfare system. Service needs for this group of children are very different and require staff to assess needs specific to adolescents and to be aware of the availability of services to meet that need.

Recommendation #35

That where numbers warrant, an adolescent unit within the local child welfare office and intake agencies be developed which will assess and provide services to adolescents.

Recommendation #36

That the Child Protection Branch undertake a review of service needs for adolescents, paying particular attention to models of practice that recognize the unique needs of adolescents and that a report outlining the findings be made available to the Department of Family Services and Housing by December 2007.

8.3 'Aging Out' of Care

Each year, Manitoba discharges hundreds of youth from the care of a child welfare agency. In many cases, these children have spent a good portion of their lives in a combination of foster care settings and/or some type of group home or institutional care. A number of these children were unprepared to undertake many of the roles and responsibilities inherent in assuming adult life in the community. Research in the United States shows that of those children who were discharged from care, fewer than half are employed; 44% have not finished high school and 25% had experienced some homelessness within one year of discharge.[70]

The review noted the high number of youth suicides among 17 year old children. This would suggest that these youth are still struggling with many adolescent issues and are not ready to leave the care of an agency or live independently in the community. The review was also concerned that this high rate of suicide among children in this age group might be signaling an additional stressor for the youth as they begin to fully understand what little support they will be receiving once they turn 18.

[70] Choca, M., Minoff, J., Andene, L., Byrnes, M., Kenneally, Norris, D., Pearn, D., Rivers, M. (2004). Can't do it alone: Housing collaborations to improve foster youth outcomes. *Child Welfare* 82 (5). Pgs. 469-492

Perhaps one of the most vulnerable groups in this regard is the youths with FASD and/or mental health concerns. These children have permanent disabilities which create ongoing struggles and which may affect their ability to live independently in the community. However, in most cases, the youths' disabilities are not seen as severe enough to warrant support through Manitoba's Adult Living Programs, nor sufficiently at risk to receive supports from the Provincial Special Needs program. Those who do qualify often find that their service and programming needs are not compatible with individuals possessing more severe intellectual delays. As a result, they tend to be poor candidates for supported employment programs and/or group home-type programs.

A landmark study conducted by Anne Streissguth over a 22-year period shows that, at 21 years of age, 80% of youth with FASD were unable to live and work independently in the community, 60% had dropped out of school and up to 90% had ongoing mental health issues. In fact, in her sample, only 7 out of 90 adults were able to live and work independently without extra supports. One of the study's recommendations includes:

> "Develop and test modifications of eligibility criteria for the Division of Developmental Disabilities. Enhancing eligibility for case management, job coaching, and supervised housing should reduce the level of costly secondary disabilities among individuals with FAS/FAE who are unable to live and work independently but are now unable to get appropriate services whenever they have an IQ above 70 or lack a full FAS diagnosis."[71] (pg 38)

There is an interesting 'disconnect' when it comes to children with FASD, seen often as perhaps the most vulnerable children in the child welfare system. While most of these youth received a high level of support as children in the care of a child welfare agency, these services are often not available after the child turns 18. Children with FASD are often expected to 'fend for themselves' with very few community resources available to advocate effectively on their behalf. As a result, many of these youth become, homeless or involved with the criminal justice system. Some estimates suggest that up to one-third of individuals currently incarcerated in Manitoba's jails have been prenatally exposed to alcohol and/or drugs.

There is provision in the child welfare act to extend services to children in care until their 21st birthday. This provision was designed to give vulnerable youth extra time to ready themselves for assuming adult roles and responsibilities. In practice, however, extensions of care are generally granted to youth who are either candidates for an adult living program or who are attending school on a regular basis. This practice, in effect, excludes most children with FASD as they are generally not in school and/or not eligible for adult living programs.

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[71] Streissguth, A., Barr H., Kogan, J., Bookstein, F. (1997) Primary and secondary disabilities in Fetal Alcohol Syndrome. In Streissguth, A., Kanter, J. (Eds.) The Challenge of Fetal Alcohol Syndrome: Overcoming Secondary Disabilities. Washington: University of Washington Press.

Research shows that many of these children have slower maturation rates and are among the most vulnerable in our community. Therefore, it seems reasonable to extend their care and to provide them with programs that will help them once they leave the child welfare system.

The review was also concerned with situations where the child had received a high level of funding and support while in the care of an agency. In many of these cases, these same needed supports and funding levels would not have been available to those youth once they reached the age of majority. The deaths of these children served to demonstrate the level of vulnerability for high needs children in the community and, as such, gives cause for concern about similar situations.

Upon exploring this area further, the availability of supports for youths with FASD who have aged out of care was reviewed. The team was surprised to find that the only agency serving these young adults is FASD Life's Journey located at 222 Osborne St. This agency offers help in securing funding, finding housing and employment, offering a food and clothing bank and serving as advocates for young adults with FASD when they encounter trouble. However, the team was disappointed to hear that, due to funding restrictions, this agency is only able to provide ongoing supports to youth who have received funding through Manitoba Community Living, the Provincial Special Needs Program or the Community Mental Health Program.

It appeared to the team that services such as FASD Life's Journey Inc. should be available to act as advocates and provide support to young adults with FASD. This might include drop-in advocacy and support when needed, referrals to other agencies and supports and assistance in negotiating situations which negatively affect the individual's ability to live in the community. This service will not only provide some support for these vulnerable young adults, it may also prevent that person from making poor choices that have long-term implications.

Recommendation #37

That the Department of Family Services and Housing develop a policy paper regarding the needs and available supports for youth who are transitioning out of the child welfare system, ensuring that an ongoing support system has been established as they exit the child welfare system.

Recommendation #38

That the Department of Family Service and Housing develop a policy paper regarding the needs and available supports for youth with FASD who are transitioning out of the child welfare system.

Recommendation #39

That the Child Protection Branch reconsider its policies regarding extensions of care to vulnerable youth with FASD, ADHD, Learning Disabilities and/or mental health issues who would otherwise not qualify for existing external services, to ensure that youth who are unable to live independently with success are provided with the supports they need between 18 to 25 years of age.

Recommendation #40

That the Department of Family Services and Housing provide baseline funding to the FASD Life's Journey program in Winnipeg, and open a similar program in Brandon and Thompson, to provide advocacy and support to young adults with FASD who are emancipating from the child welfare system.

8.4 Safety Planning for Missing Children and Adolescents

The *Stolen Sisters*[72] report documents the increased vulnerability of Aboriginal women in Canada. This report suggests that Aboriginal women are more likely to go missing and die as a result of violence more so than non-Aboriginal women. The report also documents the problems family members have in reporting a missing person and their feelings concerning how the criminal justice system may respond with less urgency to situations in which an Aboriginal youth was reported missing as compared to other 'missing person' reports. This is especially true for adolescent girls growing up in care who, when missing, are often seen to have gone AWOL (absent without leave) [73] rather than being in a potentially dangerous situation.

The cases reviewed in this study have indicated that high-risk children most often have been reported as AWOL from agency placements. In some cases, current photographs or identifiable information may have aided the police in locating that adolescent. However, in many cases, it is often difficult to locate a current photograph of that child, especially if case files are stored in secure locations away from the office that is reporting that disappearance or if the 'designated after-hours agency' is not the agency caring for that child.

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[72] Amnesty International (2000). Stolen Sisters: A Human Rights Response to Discrimination and Violence Against Indigenous Women in Canada. Report downloaded from: www.amnesty.ca on Thursday August 24, 2006.

[73] AWOL is an abbreviation for 'Absent Without Leave'. The term is generally used in relation to children in care that are missing from their foster home, group home and/or institution.

Most experts in the field would suggest that the faster the information can be disseminated to the police and press, the better the chance of locating the child or youth. Statistical information such as height, weight and clothing worn, along with a recent photograph of that child, provides useful information to the local police who are searching for the child. If this material is available in electronic format, it can also be sent to other police detachments and other provincial offices.

In speaking with representatives of the Winnipeg Police Service, the Review Team heard about an innovative project initiated by the Child and Family Support Branch entitled the 'Youth Identification Project.' This project will partner the Winnipeg Police Service Child Abuse and Missing Persons Unit, with CFSIS to be able to provide instant alerts in situations where a child is believed to be in imminent danger. The project may also help identify and recover children being exploited through the Internet and children in other dangerous situations. The Review Team endorsed this initiative and noted that it was an exciting project that had the potential to increase the safety of children in dangerous situations.

Recommendation #41

That agencies support and endorse the Manitoba Youth Identification Project by ensuring that digital photographs are available for all children in care so that, in case of an emergency, photographs of the child can be quickly distributed to the police and/or press.

Recommendation #42

That agencies undertake to develop a library of digital photographs of children in their care to be used in cases of emergency.

8.5 Drug Awareness and Treatment

During the course of the review, it was noted that a high number of youth, at the time of their death, had been under the influence of intoxicants. Many of these youth had a history of drug use and, in at least one case, the drug use was sufficiently chronic to lead to death.

Increased use of illegal drugs by youth, particularly crack cocaine, Talwin and Ritalin mixes and crystal methamphetamine, is of concern to many social workers, as well as parents, police, schools and community agencies. Such usage is often linked to gang activity and sexual exploitation which further increases the risk to the safety of children and youth.

The Review Team met with representatives of various agencies regarding issues related to adolescent addictions of alcohol and drugs. All agencies expressed concern that current services are not responsive to the special needs of adolescents with alcohol and drug abuse issues. Community members spoke about the long waiting lists to access a treatment program and current policies that discharge youth after a 'slip' while in treatment despite the fact that the individual is prepared to go back and continue treatment. Further, law enforcement officers were concerned that there were no services available to hold youth for short periods of time to keep them safe when under the influence and/or help them begin the detoxifying stage of drug and alcohol treatment.

The review was pleased to hear that *The Youth Drug Stabilization (Supports for Parents) Act* was passed on June 13, 2006 and will come into effect on November 1, 2006. *The Act* allows a provincial court to issue an order under which a person under the age of 18 can be taken to a designated facility for assessment by addiction specialists to determine if it is in the youth's best interest to be detained for stabilization. It is believed that this Act will serve up to 200 Manitoba youth annually.

While this initiative is an excellent beginning, there was the concern that once youth had made a commitment to treatment, the treatment should reflect some of the unique needs of this population. In particular, the Review Team was concerned about current philosophies regarding 'readiness' which suggested that drinking or using drugs while in treatment signaled a lack of commitment to the treatment process and was grounds for immediate discharge from treatment. It is believed that this ideology did not reflect the needs of teenage drinkers who required a program that built 'slips' into the treatment process as a learning opportunity.

Recommendation #43

That child welfare staff and placement caregivers be provided with training to assist them in recognizing the signs of drug and alcohol abuse and to be made aware of resources that are available to help.

Recommendation #44

That the Departments of Health and Justice commit funding for enough youth addiction treatment beds to ensure that treatment is available to youth within four weeks of referral.

Recommendation #45

That the Addictions Foundation of Manitoba review its current policies concerning treatment models for addicted youth with consideration given to reconsidering policies on 'personal readiness' for treatment.

8.6 Cultural Awareness

Child protection work is an area of practice that arguably raises some of the most complex ethical issues for social workers. On the one hand, the worker's job requires that he or she intervene to protect children; however, he or she is also expected to provide this service in ways that maintain the cultural identity, values, autonomy and integrity of children and families. Further, the worker must be aware of any critical issues or considerations that will influence the family's involvement with child welfare services.

It had become evident through reviewing the child deaths that recently immigrated families are some times fearful of approaching child welfare agencies for assistance as their prior experience has taught them to be wary of involving government authorities in family struggles. As a result of this, when a child becomes known to the child welfare system, the family may refuse any type of intervention. In one situation, timely intervention might have helped save a life taken by homicide.

Unfortunately, as Quinones-Mayo & Dempsey (2006) suggest, immigrant and refugee families often find it difficult to understand their children who have either adopted the culture of their new home and/or learned to blend the culture of their old and new communities.[74] Owen and English (2006) suggest the need for 'cultural brokers' to mediate cultural differences and build trust between recent immigrants and child welfare staff.[75]

A recent news release from Manitoba's Minister of Labour and Immigration on May 29, 2006, suggested that Manitoba is 'on pace' for reaching its goals of welcoming 10,000 new immigrants into Manitoba. Some of these immigrants will experience struggles with transitioning into their new homes and some will need the occasional help of a child welfare agency. It was felt that it was now time to do some focused work on community building with some of this population. This can be done by the development of a short introduction session to the child welfare system which would be offered to various community organizations working with new immigrants and refugees.

The Review Team also noted that additional training in cross-cultural issues would be helpful to child welfare workers who will be working with some of these groups. The Review Team believes that, rather than having a 'stand alone' program for child welfare workers, this material should be integrated into the current Competency Based Training curriculum to ensure that all child welfare workers undertake similar training in the area.

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[74] Quinones-Mayo, Y., Dempsey, P. (2006). Finding the Bicultural Balance: Immigrant Latino Mothers Raising 'American' Adolescents. Child Welfare 84 (5). Pgs. 649-667.

[75] Owen, C., English, M. (2006). Working Together as Cultural Brokers by Building Trusting Alliances with Bilingual and Bicultural Newcomer Paraprofessionals. Child Welfare 84 (5). Pgs. 669-688.

Recommendation #46

That Competency Based Training (CBT) include a module that focuses on anti-oppressive and anti-racist principles within a strength-based perspective. Given their role in setting the tone and values for their teams, a module should also be included in training for supervisors.

Recommendation #47

That the Child Protection Branch work with immigrant and settlement organizations in Manitoba to develop workshops on the role of the child welfare system in Manitoba and that these presentations be offered on a regular basis to refugee and immigrant groups.

Gay, Lesbian, Bisexual and Transgendered Youth (GLBT)

Youth in care with sexuality and sexual orientation issues can create some apprehension among child welfare workers. Workers may find they have little information about the topic and may have preconceived notions about the lifestyle of gay, lesbian, bisexual and transgendered people. Further, some workers may be opposed to providing an opportunity for emerging GLBT youth on religious grounds. In these cases, this may mean that workers will need to move outside of their 'comfort zone' when working with families and/or children and youth who are gay, lesbian, bisexual or transgendered (GLBT).[76]

Research shows that gay youth are 13 times more likely to commit suicide than their heterosexual peers.[77] The risks are higher when youth do not have a vehicle for talking about their feelings and/or label those feelings as deviant. Further, they may not be given information regarding 'safe sexual practices' by an individual who is aware of the range of activities undertaken by other GLBT youth and adults. The support of an adult, who is able to help youth understand that homosexuality is not a deviant lifestyle and that they are not alone, is imperative during this critical phase of the youth's adolescence.

Recommendation #48

That child welfare agencies make available to all interested adolescents, information regarding gay, lesbian, bisexual and transsexual resources that are available in the youth's community.

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[76] An excellent resource on 'Oppression' can be found in Bishop, A. (1994). Becoming and Ally: Breaking the Cycle of Oppression. Halifax: Fernwood Publishing

[77] Lebson, M (2002). Suicide Among Homosexual Youth. Journal of Homosexuality 42 (4), pgs. 107-117.

8.7 Fetal Alcohol Spectrum Disorder (FASD)

The Child Welfare League of America has reported that children with FASD are among the fastest group of children currently accessing the child welfare system. In the United States, an increase in alcohol and drug use among women has resulted in an increase of 60% more children coming into care since 1986, with an estimated 80% of alcohol affected children entering and growing up in the child welfare system before they are five years old. Unfortunately, most of these children never return to their family of origin and instead mature within the child welfare system.[78] These issues are further compromised by multiple moves within the child welfare system and an increase in institutional-type placements as the child's needs increases.[79] The maintenance costs alone for keeping a child with FASD in the child welfare system can range anywhere from $18,000 a year for a child in a family-type foster home to over $95,000 a year for a child in an institutional setting.

Children with FASD are somewhat unique in the child welfare system as the combination of their behavioural and developmental needs are often compounded by struggles facing their addicted parents, and a high potential for increased levels of physical and emotional abuse early in life. This makes these children among the most vulnerable children within the child welfare system and the most likely to put themselves in harm's way. Research shows that mortality rates among alcohol affected children may be up to three times the rates noted in non-disabled children.[80]

The Review Team noted the high number of children in this study to which FASD was seen as a contributing factor in the death of that child or youth. About one-third of the CME reports reviewed mentioned that FASD, or suspicion of FASD, was a contributing factor in the death of that child or youth. Issues or contributing factors ranged from children who died soon after birth as a result of complications related to prenatal alcohol use to youth who put themselves in harm's way because they struggled with impulsivity and/or weaknesses in judgment.

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[78] For a fuller discussion on this theme see Besharov, D. (1994). *When Drug Addicts Have Children: Rethinking Child Welfare's Response*. Washington: Child Welfare League of America.

[79] See Jones, K. (2003). Successfully raising resilient foster children that have Fetal Alcohol Syndrome: What Works? *Envision: The Manitoba Journal of Child Welfare 3* (1) for a further discussion of this theme.

[80] Torrence, C. & K. Horns (1989). Appraisal and caregiving for the drug addicted infant. Neonatal Network 8(3). 49-59.

Best practices in the field of FASD suggest that children have the best outcomes when they are diagnosed before the age of five and grow up in a safe, non-violent home.[81] Studies also show better outcomes when children with FASD live in a stable and consistent home with as few changes as possible. This would also include reducing the number of moves that children make within the child welfare system.[82]

Judge Gregoire echoed these comments in the Beaulieu Inquest, suggesting that more supports needed to be available for children affected by prenatal alcohol use. This included early identification and early supports for children suspected of being affected by prenatal alcohol use.

In the inquest report, Judge Gregoire spoke of the testimony of Dr. A. Chudley, a noted FASD expert in Manitoba:

> "One of the issues touched upon in Dr. Chudley's examination was why is the diagnosis important? It is his firm belief that there is often a change in attitude towards the child by caregivers when they realize that child has actual brain damage. It also alerts physicians to look for other things such as hearing loss, which is found in about 20% of children exposed to alcohol in utero." (pg 75)

In exploring issues related to the diagnosis of children and youth, the Review Team noted that while the *Clinic for Alcohol and Drug Exposed Children* (Health Sciences Centre) provides diagnosis for children under 12, due to funding issues, the clinic is unable to see older children and youth. This is unfortunate because at least three of the youth in the suicide, homicide and accidental death group came into care later in their lives and were undiagnosed. Had these families and/or the agency had a better understanding of that youth's disability, the youth may have received a higher level of understanding and support in the management their needs. This might have included a higher level of supervision, an increase in healthier recreational activities and increased support at home and in school.

The Review Team also determined that more attention needed to be paid to program planning and delivery for children and youth suspected of being FASD. It was noted that two child welfare agencies had developed specialized FASD programs which include an FASD specialist as part of the treatment team. This staff person is used as a resource for families and child welfare workers to help develop better plans for affected children. This specialist offers consultation on best practices in the area of FASD for children in care and in danger of coming into care, liaises with the schools, provides referrals to outside agencies and arranges appointments to the diagnostic clinic.

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[81] Striessguth, A & J. Kanter. (1994). The Challenge of Fetal Alcohol Syndrome: Overcoming Secondary Disabilities. Seattle:University of Washington Press.

[82] Jones, K. (2004). Successfully Raising Resilient Foster Children with Fetal Alcohol Syndrome- What Works" Envisionjournal.com.

The costs of this program, about $80,000 per agency[83], is equivalent to the difference between keeping one child in a family foster home setting and maintaining that same child in an institutional setting. A dedicated FASD staff person in each agency would help reduce some of the maintenance costs associated with keeping children with FASD in care, as well as provide for better outcomes for children in the long-term.

Recommendation #49

That funding be made available through the Department of Family Services and Housing to hire FASD specialists in each child welfare agency. These individuals will help increase opportunities for diagnosis of children suspected of being FASD, as well as work with front-line workers, foster parents and caregivers to develop better case plans for alcohol/substance affected children.

Recommendation #50

That comprehensive training in FASD specific to the child welfare system be undertaken by all child welfare agencies.

Recommendation #51

That the Clinic for Alcohol and Drug Exposed Children at the Health Sciences Centre be funded and allowed to provide diagnosis and consultation for youths aged 10 to18 who are suspected of being prenatally exposed to alcohol and/or drugs.

[83] This figure is based on the average cost of one FTE within the child welfare system.

9.0 System Breakdowns

One of the questions that prompted this and other reviews to be undertaken in the summer of 2006 was whether changes in the child welfare system over the past three years lead to the breakdown of systems that put children at risk.

While it appeared to the Review Team that the transition of child welfare did not directly result in increased risks for children, it was noted that these changes have created some new challenges for the system as a whole. Increased intervention in these areas would help increase communication between agencies, improve service delivery and create a better system for children and families overall.

9.1 Interagency Communication

The environment of change within the child welfare field in the past several years necessitated a smooth and effective communication system between agencies to ensure that agencies have the ability to 'red flag' situations that require immediate attention. When agencies are unaware of how to effectively communicate with the receiving agency and do not have a full appreciation of the agency philosophy and internal operating procedures of that agency, effective communication regarding the safety of children and families may be compromised.

In some cases, there were issues with the lack of clear protocols regarding the transfer of files from one agency to another. In general, this was related to transfers occurring after the initial AJI transfers. Further, there was a high variance in agency protocols for sharing information between agencies. Issues noted included poor information in sharing regarding 'high risk families' who were changing jurisdictions, the inconsistent dissemination of birth alerts, and AWOLs to agencies and the process of providing a full family history when preparing to transfer cases from one agency to another. This was an emerging issue before the AJI-CWI case transfers and continues to be an area that has the potential to lead to serious consequences in the future.

Two issues emerged from the review: a) the appropriate transfer of files from one agency to another, and b) the use of alerts and the Child and Family Services Information System (CFSIS) to access information regarding a child or family.

Transferring Files

The *Manitoba Program Standards Manual* sets out regulations regarding the smooth transfer of a child from one agency or jurisdiction to another. Section 1.1.6. of the Program Standards Manual reads:

> "2. Transfer to Another Agency - When the transfer is from one agency to another in Manitoba, the supervisor ensures that
>
> - the receiving agency provides written agreement or confirmation that it will assume responsibility for the case and the date it will do so before transferring the case
> - forwards the case record to the receiving agency by the transfer date with appropriate documentation including the most recent:
> - information on persons in the case
> - assessment and planning information
> - family service documents
> - court documents
> - monitoring and review (evaluation) information
> - when transferring supervision of a child in care, provides the receiving agency with a completed transfer summary including the case plan and an updated service description

The Review Team noted that, in general, agency staff have not been given sufficient information regarding some of the new protocols associated with new agencies and new mandates. There continues to be some 'growing pains' regarding how to work within a new and very complex system. Staff report that they are often confused about jurisdictional issues, the location and mandate of new agencies and the agency contact person when making a referral.

Staff at the receiving agency also reported that when transferred, files were often lacking important information including assessments, previous reports and contact information. In these cases, staff must search for additional information not found in the transfer summaries, a process that is time consuming and which may lead to poor 'risk' assessments as a result of a lack of information.

Finally, the Review Team noted that staff adherence to standards[54] on case transfers is intermittent at best and reflects the general lack of knowledge and understanding of the emerging system. Team members believed that this reflected a lack of training offered to staff about transferring cases and the new system in general.

Recommendation #52

That information or training be offered to all agency staff regarding the location, jurisdiction and practice of all child welfare agencies within the province of Manitoba. This training may also include information regarding agency protocols, contact people and a review of provincial standards regarding case transfers.

Recommendation #53

That the Child Protection Branch and the four Authorities ensure province-wide adherence to section 1.1.6 of the Standards Manual regarding Case Transfers.

Recommendation #54

That the Joint Intake and Response Unit (JIRU) undertake a series of informational training sessions in agencies operating in Winnipeg to provide information about their service.

Agency Alerts

The second area of concern in the area of interagency communication is the practice of alerting other agencies when a family known to one system moves to another jurisdiction. This might include the provision of 'birth alerts' which are alerts sent to agencies and hospitals warning of an impending birth of a child to a 'high risk' mother, as well as general 'alerts' to advise other agencies of AWOLs, emerging or pending child protection concerns and/or reports of family situations that have the potential to become volatile. These alerts are provided by written communication to receiving agencies and/or through the posting of information on the provincial Child and Family Services Information System (CFSIS).

When sending alerts to receiving agencies, notices of concerns relating to the protection of the family were sent, but were not always followed up by the sending agency. The Review Team also noted that formal written information was not always followed up with a phone call to the receiving agency to ensure that the material was sent and had been received.

[54] Issues related to the lack of adherence to Standards are also noted throughout this report and reflect a general lack of knowledge of the Child and Family Standards Manual. A fuller discussion of the issue of adherence to standards can be found later in this report.

Workers also told the Review Team that the information offered through the Child and Family Services Information System (CFSIS) was limited and sometimes incorrect, making it difficult for receiving agencies to gain additional information when a child protection issue presented itself in their jurisdiction. Finally, it was noted that CFSIS was not universally available and used in all agencies in Manitoba, leading to gaps in the collection of information regarding 'high risk' families.

The Review Team experienced first-hand some of the issues with the inconsistent collection of CFSIS information in its own review. In many cases, information regarding the family situation, including important reports and agency contact people, was found to be outdated and/or wrong. This led to some frustration on the part of the Review Team who noted that inconsistent and/or incomplete record keeping had the potential to lead to a far more serious concern when and if an agency worker was attempting to obtain additional information regarding a volatile situation in a timely manner. Not having easy access to this type of information could ultimately lead to children, youth and families being put at risk that, in turn, could lead to serious injuries or the death of a child.

While there continues to be protocols for the dissemination of 'alerts', provincial standards regarding the use of 'alerts'[85] has been absent from the Program Standards Package since January 2000. As the system has experienced a large influx of new staff representing new and expanding agencies, it seems useful to update the Standards Package to include protocols in this area.

Recommendation#55

That the Child Protection Branch reinstate standards regarding 'Alerts' in the Program Standards Manual.

Recommendation #56

That the Child Protection Branch develop protocols that ensures that child welfare agencies be required to undertake a complete background check when families requiring service move into their jurisdiction or have changed service providers.

9.2 Communicating with Collateral Agencies

The expansion of the child welfare system has led to a corresponding increase in the use of community-based supports. These supports can aid the child welfare worker in ensuring that children and families develop healthy support networks within their own community. In his study of family functioning in an urban setting, Fuchs noted that parents with more connections within the community have healthier relationships and are overall better parents to their children.[86]

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[85] Standards on Alerts can be found in Section 325.10 in the 1994 Provincial Standards Package.

[86] Fuchs, D. (1995). Preserving and strengthening families and protecting children: Social network intervention, A balanced approach to the prevention of child maltreatment. In Hudson J. & Galaway B.

In order for a community-based child welfare service to be effective, it must also rely on information regarding the safety of children received from external organizations, children's services and schools. Early and effective reporting not only protects children from ongoing harm, but also helps agencies intervene with the family as early as possible so that they are able to receive the support needed to ensure that their children receive the attention and care required so that the parents can re-establish their role as guardians of their children.

The Schmidt Inquest explored the issue of communication between secondary resources and effective reporting to authorities when child safety is at risk. The report made eight recommendations, five of which dealt directly with standards regarding communication between outside agencies and the child welfare system. Unfortunately, this study found that despite the publicity surrounding the need to be more proactive in the area, concerns regarding the relationship between community agencies and the child welfare system still persist.

Use of Secondary Resources

Secondary resources are community-based child or family resources offered outside of the child welfare system which are designed to enhance services to high-risk children and families. Services considered to be 'secondary resources' include specialized treatment-type group or foster homes, parent support programs, treatment resources, daycares and shelters, and medical services for mothers or children. Ideally, these agencies link together to form a team or web, in which each provides their portion of the service needed as well as working in tandem with other supports, to build a strong support network for the child and family. Implicit is the notion that these services do not and should not take the place of statutory services as required by *The Child and Family Services Act*.

While in theory, the role of secondary resources appears clear, in practice some agencies struggle with their role within the system and, in particular, with the families accessing these services. Teamwork within the support network breaks down when there is an unclear definition as to what role each community agency plays in the provision of services to the child or family. This issue becomes far more complicated when there is no clear contract regarding the role of each member of the treatment team, when workers do not share information about issues related to the client with the child welfare worker, and/or when mandated child welfare workers do not maintain a visible presence within the treatment team. This is of particular concern when a child's safety has been compromised by poor communication between agency resources.

(Eds.) *Child Welfare in Canada: Research and Policy Implications* (pp 113-122). Toronto: Thompson Educational Press.

Issues related to the role of staff in secondary resources became a central theme during the 2003 Schmidt Inquest. Judge Conner's fifth recommendation read:

> "That the Minister immediately ensure that a service contract or a written confirmation is employed in every situation where there is an expectation on the part of a mandated agency that a collateral agency or service provider will report information and/or provide services. The service contract or written confirmation shall contain the mandated agency's reporting requirements and expectations as well as the collateral agency's or service provider's agreement to report the required information. In the case of the provision of service, the service contract or written confirmation shall contain a description of the service to be provided. The mandated agency should be required to include all essential conditions in the service contract or written confirmation."

The Review Team found that, despite the recommendations of the Schmidt Inquest, communication between agencies continues to be problematic. This review found that secondary resources to the child and family did not consistently provide the mandated agency with ongoing information about the family's progress and, in some cases, did not share with the child welfare worker that the child or family had refused services. This lack of information created a clear hazard for the child welfare worker whose case plan was premised on the notion that the family was attending and showing progress in support programs. In other cases, the collateral agencies performed services outside of the scope of their mandate that were in clear violation of *The Child and Family Service Act.*

It should also be noted that problems with clearly defined role definitions between team members is not solely the responsibility of the collateral agencies. The Review Team noted cases in which the mandated child welfare worker did not perform the prescribed statutory duties to meet with a foster child on a monthly basis assuming that the agency providing secondary services was supervising the foster home. Once again, it should be noted that monthly visits by the assigned child protection worker are mandated by *The Child and Family Services Act.*

In general, in spite of the recommendations regarding clarification of the role of each team member contained in the Schmidt Inquest, confusion still exists when these resources are used.

Recommendation #57

That the Child Protection Branch reaffirm to agency directors the necessity to follow agency standards regarding home visits, on-going communication with collateral agencies and regular service meetings when using secondary resources as part of a child or a family's case plan.

Duty to Report

Section 3(18) (1) of *The Child and Family Services Act* outlines issues related to the duty to report when an individual believes a child is in need of protection. The section reads as follows:

> "Subject to subsection (1.1), where a person has information that leads the person reasonably to believe that a child is or might be in need of protection as provided in section 17, the person shall forthwith report the information to an agency or to a parent or guardian of the child."

Training in the area *of The Child and Family Services Act,* specifically an individual's 'duty to report,' is offered in most professional schools, as well as in agency handbooks and other professional materials. Despite this, some confusion still exists as to when and how to report suspected abuse. In some cases, this reluctance is based on a desire not to get 'involved'. In other cases, professionals believe that reporting abuse will compromise their professional relationship with the child or parents. Others have told the Review Team that under *The Freedom of Information and Protection of Privacy Act (FIPPA),* they are obligated not to disclose any information about their clients or their children.

The *Child and Family Services Act* provides for the reporting without compromising confidentiality as outlined in the Freedom of Information and Privacy Act. Clause 86.1 reads:

> "Conflict with *The Freedom of Information and Protection of Privacy Act*
>
> 86.1 If a provision of this Act is inconsistent or in conflict with a provision of *The Freedom of Information and Protection of Privacy Act*, the provision of this Act prevails."

In reviewing the situation of the children in this study, there were at least four instances in which staff from community agencies struggled with reporting situations in which a child was in a dangerous situation because they did not understand their obligations and duty to report this suspected abuse. In two other situations, medical professionals failed to report patients who were in imminent danger because they believed that under FIPPA, they could not release information about a patient without the permission of the child's parent(s).

Failing to report situations in which a child is in danger puts children at risk for ongoing abuse and/or serious injury or death. For example, in one tragic case, the child's physician commented to the agency worker that she had concerns about the child when the child had been seen in the doctor's office. This had been shared after the child's death. In the event that the physician had shared that information with the case manager in a timely fashion, crisis services could have been put into place that might have prevented the death of the child.

It is unfortunate that more professionals are not aware that in the case of suspected child abuse, the provisions of *The Child and Family Services Act* overrides FIPPA legislation.

Section 4(2)(b.1) of *The Act* states:

> "(b.1) require any person who in the opinion of the director is able to give information relating to any matter being investigated by the director.
>
> (i) to furnish information to the director, and
>
> (ii) to produce and permit the director to make a copy of any record, paper, or thing that, in the opinion of the director, relates to the matter being investigated and that may be in the possession or under the control of the person.

In 1999, the Province of Manitoba issued guidelines for reporting child protection to external parties in order to inform externally of the obligations to report child protection issues. These guidelines were revised and reissued in 2001. In the preamble, the updated guidelines state:

> "The Ministers of Family Services and Housing; Justice; Education; Training and Youth; and Health jointly have issued these guidelines in recognition of the need for a community-based multi-disciplinary team approach to respond to child protection and child abuse. They explain the basic obligations under *The Act* to report a child in need of protection and outline the steps to be followed by the various disciplines involved in the investigation and management of child abuse and child protection cases."

It has now been five years since these guidelines have been issued. During that time, the child welfare system has gone through unprecedented changes that have led to the inception of new agencies with new duties and responsibilities. Updating and re-issuing guidelines regarding protocols for reporting abuse, as well as information reminding professionals that in cases of child endangerment, *The Child and Family Services Act* takes precedent over FIPPA legislation would be a useful undertaking at this time.

Recommendation #58

That a provincial directive be issued and that a training module be developed on the "duty to report" and on the role of the Privacy Act with respect to child welfare investigations.

Recommendation #59

That the booklet "Guidelines for Reporting Children in Need of Protection" be distributed by the Child Protection Branch to all pertinent professionals on a yearly basis.

Recommendation #60

That the Child Protection Branch develop a brief presentation and make it available to all community organizations through an information session on The Freedom of Information and Protection of Privacy Act (FIPPA) and Section 18 of The Child and Family Services Act with respect to their duty to report protection concerns of children.

9.3 Training and Compliance with Provincial Standards

Mandates concerning the provision of child protection services in Manitoba are legislated through *The Child and Family Services Act*. Standards related to the manner in which those services are provided are outlined in the Manitoba Child and Family Services Standards Manual. These standards are generally related to the care and safety of children, and are considered within the field 'minimum standards' with the expectation that agencies will be able to customize standards to meet their own community's needs and expectations.

When working within a system with both significant powers and responsibilities, it is important to ensure that all staff is aware of, and comply with, both *The Act* and adjoining standards. When agency staff and management are not well schooled in the rules and standards of practice, children can be put at risk.

In meeting with many child welfare workers regarding the death of a child on their caseload, the Review Team was surprised to learn that the majority of staff reported that they were not as aware of their standards of practice as they should be. Most staff reported that they felt they had a good working knowledge of *The Child and Family Services Act*, but often depended on their supervisor to ensure that standards were met. This can create problems when front-line staff are not aware of a problem and are, therefore, unable to share concerns with their supervisor, or when workers must act immediately and do not have the time to properly consult with their supervisor.

It is the understanding of the Review Team that standards training is included in the Competency Based Training package offered through the Child Protection Branch. However, due to funding constraints and staffing shortages, child protection workers often start their first day at an agency with a full caseload of clients and do not have the time to attend training until well into their employment with the agency.

Justice Conner speaks of this issue in the Schmidt Inquest:

> "CFS experiences a high turnover of child protection workers, no doubt due largely to the inherent stresses of the position and the high workloads. This means that new workers are hired on a regular basis and must be trained in the specialized area of child protection work, which they do not receive in the general social work program. At present, when new workers are hired the demands of the workloads and lack of adequate staffing require that they be given near to full caseloads at the outset." (pg 163)

Workers also reported that high caseloads and increased responsibilities have drastically reduced the amount of time workers have to attend training. This issue was highlighted again in the 2003 Schmidt inquiry. In his final report Judge Conner writes:

> "The potential consequences of continuing to operate with excessive workloads are extremely serious and far-reaching. From the public perspective, by representing that there are prescribed minimum standards of service being delivered to protect children in Manitoba, when those standards cannot practically be achieved, creates unrealistic expectations. From the perspective of CFS, the stress imposed on workers and supervisors of having to make choices and judgment calls on matters affecting the well-being of children is unacceptable. The practice has necessarily become one of "crisis management" rather than proper social work practice. More importantly, the protection of children is at risk. When a child is harmed or dies, the reality is that it is the conduct of the individual workers and supervisors that is placed under a microscope and judged on the basis of compliance with the Program Standards." (pg 163)

The Review Team felt that children and families would be safer if workers had a working knowledge of *The Child and Family Services Act* and Program Standards earlier in their career. Further, it was noted that the Child Protection Branch recommends that new workers should be given a smaller caseload when they begin their employment so that they have the opportunity to attend training and know and understand provincial laws and child welfare standards. The inquest reported:

> "The Competency Based Training Tool Manual adopted by the Support Branch sets out the workloads that should be given to new workers during the first six months' of the worker's employment [Ex. 82, p. xiv]. The Manual provides that workers should maintain a reduced caseload, starting with three cases after the first 9 to 10 weeks and sequencing in new cases so that the worker will be responsible for 14 to 16 families, the recommended maximum for a child welfare worker, at the end of the six month period." (pg 163)

Finally, the review noted that while the current standards manual has recently been upgraded to an 'easy access' Internet format, the manual is sometimes unclear and difficult to understand. Instead, staff must rely on portions of the 1993 manual, portions of the 1999 'remnant package' and an incomplete 2003 manual. The Review Team found that as they completed this study, it was often difficult to locate information about specific standards. It was believed that if people with many years of experience in the field were having difficulty, a new staff person under certain time constraints would likely find the current situation overwhelming as well. The Review Team strongly recommends that the Child Protection Branch prioritize the completion of the standards manual.

Recommendation #61

That child welfare staff be required to complete the first module of the Competency Based Training Program within six months of beginning employment with a child welfare agency.

Recommendation #62

That the Child Protection Branch prioritize the timely completion of the Provincial Standards Manual.

Recommendation #63

That agencies follow the recommendations of the Schmidt Inquest and make as an agency policy, the reduction of caseloads for new staff during the first six months of their employment with the agency.

Recommendation #64

That the Supervisors Competency Based Training Program include a module on mentoring front-line staff to ensure that workers are aware of and comply with provincial standards.

Recommendation #65

That the Competency Based Training Program include a standard orientation to Child and Family Services including information about The Act, standards and operating procedures which child welfare staff would take as mandatory training prior to caseload assignment.

9.4 Interjurisdictional Issues

Changes in the child welfare system over the past few years have led to increased questions as to which agency has jurisdiction over the support of First Nation children in cases of child protection, child maintenance and specialized services. These issues are not new to the Manitoba child welfare system and did not 'begin' during the devolution of the child welfare system beginning in 2004. Previous to the 1980's, child protection services were provided through a combination of private agencies and the provincial government which served all Manitoba children, including children living in First Nation communities. Services were inconsistent and often resulted in the child being taken out of the community to receive services.

In the early 1980's, under a tripartite agreement between Indian Affairs and the Province of Manitoba, First Nation agencies began to provide services in First Nation communities. The rationale for the application of provincial child welfare legislation to these communities was provided under Section 88 of the Indian Act. Indian and Northern Affairs provided funding under a population-based funding formula known as Policy 20.1. The federal government has maintained that this role is not a fiduciary obligation but a matter of administration and that their provision of services for First Nation people is 'discretionary'. They have stated that:

> "DIAND's perspective is that provinces delegate authority to agencies and are thus responsible to ensure that the agency operates pursuant to the established standards. Where deficiencies are observed it is the role of the province, as the substantive legislative authority for child and family services, to work with the agency to address the needed improvements. The department's role is limited to funding the provision of services delivered by agencies authorized by the province."[87]

First Nation agencies maintain that the populated-based funding model is outdated and does not reflect the costs of supporting children in remote, resource poor and isolated communities. This has led to a two-tiered system in which the costs of care for children deemed a federal responsibility are often subsidized by provincial dollars. This is particularly true of dollars allocated for prevention services. Often the lack of funding means that children must do without needed services. This is especially true for children with expensive needs and children from families who live transient lifestyles moving between a reserve community and the city. The Review Team noted that struggles in this area often affect children, families and communities that were the least able to find alternative resources and were among the most vulnerable in the province.

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[87] Excerpt from the First Nations Child and Family Caring Society of Canada (2005). Wen:De Coming to the Light. pg 89-90.

Issues with jurisdictional 'debates' were observed in two specific areas: a) determinations of which agency was responsible for providing services, and b) struggles within agencies to provide for the needs of children with disabilities and/or medical needs. The Review Team found that, on occasion, debates about responsibility led to increased workloads for workers. In other cases, debates about responsibility led to more serious consequences.

Perhaps the most troubling example of this issue was an adolescent who continued to live in temporary shelters while two agencies disputed jurisdictional responsibility for the care of that child. The issue appeared to be related to the youth's address, as his mother moved between the city of Winnipeg and a First Nation community, and the fact that the child was seen to have very high needs related to his street level activities. At the time of death, the youth was under 16 years of age.

The Review Team observed that since 2005, issues related to jurisdiction have become more complicated and require agencies to maintain a high level of communication and collegiality between agencies and workers. In cases where a dispute cannot be resolved between the agencies, there needs to be a dispute resolution process that can assist in determining a solution to these problems.

Children with Complex Medical Needs

In some cases jurisdictional debates between the federal and provincial governments are related to the lack of supports within First Nations communities for First Nation children with complex medical needs. The federal government, the funding body for child welfare services for on-reserve children, makes no provision for funding or providing extra supports for children with special needs.

The Province, in turn, argues that they have no mandate for the provision of services in First Nation communities which are a federal responsibility under the Indian Act.[88] Workers and agency representatives report that once a First Nation child with medical needs comes into care, it often takes many hours and a great deal of patience on their part to try and determine which level of government is responsible for both the provision and payment of necessary services. This is both frustrating and time-consuming, and often results in the worker having less time to spend with other children on her/his caseload.

Support to First Nation children with complex medical needs has been a subject of debate, reviews and legal challenges for many years. In previous years, a committee made up of federal, provincial and agency representatives met regularly to develop an agreement for service delivery with little success.

In 2006, funding from Health Canada resulted in a report developed by the Assembly of Manitoba Chiefs entitled *Addressing Gaps in Services for On Reserve First Nations*

[88] See Ducharme, C., Muskego, D., Muswagon, A., Paupaneckis, C., Muswagon, M., Spence, W., Ramdatt, J. (undated). *Promising Practices in First Nation Child Welfare: Kinosao Sipi Minisowin Agency Creating a Community Response for Special Needs Children* for an excellent discussion on the effects of Jurisdictional struggles on First Nation children with disabilities in Manitoba.

Children and Adults with Disabilities and their Families. This report examined gaps in services and called for better partnerships between both levels of government. Nationally, the Assembly of First Nations and other child welfare organizations have passed and supported the application of '*Jordan's Principle*'[89] which suggests, in part, that no child should have to come into care and leave their family simply because they have high medical needs.

In their recent report,[90] the First Nation Child and Family Caring Society of Canada states:

> "This situation is unacceptable and it is a violation of this child's basic human rights. Every child has the right to be raised in a family, to have their needs met and to receive quality care."

The team agreed with these comments and believed that children with special needs deserved the same quality of services as other children. The provision of that service would include ensuring that children do not have to come into care unnecessarily, that children are placed in their home community when at all possible and that all Manitoba children be provided with the same level of services no matter where they live.

The gaps between federal and provincial responsibility for the provision of child welfare services are unacceptable. Further, agencies and families should not have to wait for governments to determine who has jurisdiction over the provision of services before services can begin. This review strongly supports the provisions of '*Jordan's Principle*' and strongly recommended that the Province of Manitoba immediately adopt '*Jordan's Principle*' and immediately work towards eliminating the current impasse between the federal and provincial government.

Recommendation #66

That the Department of Family Services and Housing either appoint an independent arbitrator or constitute a committee made up of a representative of each authority, a representative of the Child Protection Branch, and up to three community representatives to act as a dispute resolution body in cases where jurisdiction is in question.

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[89] 'Jordan' was a four year old First Nation boy from Winnipeg who was removed from his home at birth due to his high medical needs and placed in a hospital under a First Nation Child Welfare agency. Despite attempts by the agency and family to develop appropriate services, Jordan was unable to move into a family home due to jurisdictional issues between the Department of Indian Affairs and the Province of Manitoba. Further information about 'Jordan's Principle' can be found on the web at www.fncfcs.com.

[90] Excerpt from the First Nations Child and Family Caring Society of Canada (2005). Wen:De Coming to the Light. pg 98.

Recommendation #67

That the province of Manitoba adopt 'Jordan's Principle' of 'Children First' as it relates to ensuring the provision of uninterrupted services to children while awaiting resolution of interjurisdictional funding disputes.

9.5 The Northern Experience

Child welfare services to northern residents creates its own challenges due to isolation, the high cost of travel and the lack of available resources. While these challenges extend to non-Aboriginal as well as Aboriginal communities, Aboriginal agencies also experience the jurisdictional issues outlined above, as well as widespread social problems which are prevalent in many northern Aboriginal communities in Canada.

Northern First Nation child welfare agencies reported to the Review Team that they often have to extend their services beyond simply providing statutory child protection services due to the shortage of professional services in the North. This may include paying the travel and treatment costs for an addicted child to attend a treatment program, and providing other necessary services as required including anger management courses to comply with court orders to ensure that mothers and children are safer. While southern agencies are able to make use of resources in neighbouring communities or band together to share a single resource, these resources are either not available within the region or, due to travel costs, cannot be shared. This directly affects the ability of the agency to employ alternatives to taking children into care.

However, workers also indicated a high level of commitment to the preservation of the family unit and expressed trepidation at having children placed in permanent care, or outside of their home community. Agency staff often play a "juggling game" to decide if the best interest of the child is staying at home and monitoring the situation or moving the child out of the community in light of the possibility of that child becoming involved in undesirable activities in the city.

Agencies are also under a great deal of pressure to provide services that are culturally sensitive and reflective of the experiences of First Nation communities. Agencies struggle in maintaining the balance between retaining culture and community while carrying out a mandate to protect vulnerable citizens. This may mean that agencies must develop their own resources that reflect the cultural and social demands of the community while recognizing the limited available resources. AWASIS agency, for example, has taken steps to train staff in risk estimation systems that are in keeping with the agency philosophy, to develop case management techniques which are more consistent with community norms and values.

In meetings with staff in the North, three workers had indicated that it was often difficult in small remote communities to find workers who possess the qualifications necessary for the intensity of child welfare work. In many cases, agencies have to rely on workers with many years of 'life experience' and less formal education. However, these workers, while quite committed to the families and children, face challenges without the formal knowledge and skills provided through an education setting. Workers suggested that this problem might be reduced if they had access to objective supervision, case planning support and interpretation of provincial regulations to help override the tendency to comply with community norms in small remote and isolated communities. One agency, in particular, outlined the need for a highly trained worker to spend time in each of their remote communities training and advising community workers. This would alleviate pressure on community workers, give them an opportunity to consult on particularly complex cases as well as ensure good case management.

In at least two of the children's deaths, the children had been returned to their biological family despite long-standing chronic alcohol and neglect issues. It would appear that the hesitation of workers to permanently fracture a family may have translated into a child's return to an unprepared environment. However, had the agency been able to use the services of a trained case management specialist and/or could access appropriate services within the community, these deaths may have been prevented. These services are expensive in the short run but may help reduce the risk to children.

Recommendation #68

That due to the high number of new or redeployed staff, agencies receive funding for and employ the use of a case management specialist whose duties would be to educate, train and organize case management in accordance with agency philosophy and resources. This individual would be expected to provide this training in the communities to which they provide services.

Recommendation #69

That a committee comprised of community health professionals, child welfare workers and community members be developed in northern, rural and remote areas to ensure a seamless delivery of services to children and youth living on and off reserve communities.

9.6 Resources

The reduction, or 'capping' of agency resource funding over the past number of years has had a profound effect on an agency's ability to provide the type of quality services that supports families, reduces the number of children coming into the care of an agency and maintains the emotional and physical health of the agency staff. It also has an effect on the ability of the worker to be able to develop and undertake case plans that not only support a child damaged by abuse but also aid in the healing of that child. This is especially important in the case of children at risk for suicide that need the active involvement of their case manager in ensuring that they have the mental health services and other resources to ensure their safety until they are able to keep themselves safe from harm. The review noted two areas that have been adversely affected by funding reductions and suggests that changes must be made in these areas to prevent any further deaths.

Caseload Size

The issue of caseload size has been a subject of debate in three recent inquests in Manitoba.[91] In each case, reports called for a review of caseload size in relation to ensuring that agency staff are given the time to commit to ensuring that all children in their care are provided with the time and attention they need to be safe, healthy and supported. Judge Giesbrecht remarked in the 2003 Redhead Inquest that:

> "It is recommended that in order to move away from a crisis style management to a situation where childcare workers have adequate time to properly manage their cases and to provide appropriate long-term planning for the children in their care, family services agencies ensure that workers have a reasonable caseload. Where a caseload consists of high needs children, a caseload in the range of 20 cases per worker should be the goal of the agency."

The Child Welfare League of America recommends a maximum caseload of 17 especially when children have needs that require intensive supports.[92] It is the review's understanding that this number is related to the number of families and the Manitoba case count reflects work with each individual child. Regardless, workers in this review routinely cited caseloads of between 30 to 50 cases which is far too high. Because these workloads are so high and lead to missed opportunities to intervene, poor case management, case planning and overall poor service to children and families is experienced.

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[91] Patrick Redhead (2003), Sophia Schmidt (2003) and Susan Redhead (2004).

[92] Standards downloaded from the Child Welfare League of America website (http://www.cwla.org) on Sept 11, 2006

Recommendation #70

That the Department of Family Services and Housing work towards ensuring that workloads are at a manageable level.

Prevention and Support Services for Families

Certainly one of the guiding principles in the child welfare field is the provision of prevention services to prevent children from coming into the care of a child welfare agency. Not only are prevention services less expensive than maintaining a child in the child welfare system, but offering targeted services early may lead to healthier children and families. Jackson (2000) supports this assertion by suggesting that:

> "Child welfare interventions are costly, time consuming and have lifechanging consequences for the people involved. Their immediate purpose may seem self-evident to prevent children from suffering harm, and in the last resort, to remove them from families who are unable to provide a minimally acceptable standard of care for them. Family preservation has displaced rescue as the intervention of choice as evidence has grown of the risks involved in separating children from their families and communities."[93]

Workers also indicated that while their mandate was to ultimately protect children, their philosophy was that their work would enable families to function in a healthy manner without child welfare involvement. Placing children in care, away from parents, was seen as a solution secondary to the ultimate solution of having children safely reside in their own homes. In order to realize these goals, time and resources are important tools to building relationships with clients and to keeping families together in a safe setting.

The Child and Family Services Act makes provision for funding of prevention and family support programs to preserve the family unit as a discretionary service provision. In 1992, changes were made to Aboriginal Agency funding which resulted in funding for Services to Families being issued in grant allocation.[94] Workers in the interviews have indicated that the capping and subsequent reductions in funding to services to families have resulted in the elimination of many family support programs and a return to agencies providing only child protection services. The submission from Awasis Agency at that time stated:[95]

> "What began in 1983 as a new vision of child welfare services to Indians within the Province of Manitoba, focus on prevention and family services,

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[93] Jackson, S (1995). Looking after children better: An interactive model for research and practice (pgs 324-336) . In Hudson, J. & B. Galaway (Eds.). *Child Welfare in Canada: Research and Policy Implications.* Toronto: Thompson University Press.

[94] As sited in AWASIS agency (1993) Research Brief into Federal Funding Changes Regarding Services to Families Dollars Submission to First Nation Child and Family Task Force.

[95] IBID

is being eroded through unilateral funding changes that, through a process of elimination, places the emphasis once again upon protection services." (pg 16)

The provision of homemakers and interveners may be more useful than to simply support families in crisis. They also help agencies develop insight into family dynamics, which may alert agencies to conditions that required attention. This may have been preventative in a number of the accidents and homicides of young children whose deaths appeared to be as a result of parent neglect or abuse, issues that a worker could have intervened with before the child died.

In one particular example, a child was returned home to the biological family who had a lengthy history with Child and Family Services. In an effort to end the cycle of involvement with Child and Family Services, the worker had returned the child to the parent with some informal supports in place. If formal supports had been employed, the agency may have been alerted to difficulties that the mother was having with parenting the child prior to the child's death.

In other instances, children had been returned to their natural families with case plans indicating that the caseworker would regularly visit the family at undisclosed time frames. In an ideal case plan, a homemaker or support worker would regularly attend the home to ensure the safety of the children. When asked about the adequacy of the case planning, both agencies cited lack of availability of in-home service funding as the rationale for the case planning. Both children died in the homes of their natural parents.

Recommendation #71

That funding for prevention and family support programs in the North be increased to ensure that adequate funding is available to provide services that are equitable to services available in the South.

10.0 Supports after the Death of a Child

The unexpected death of a child is always a tragedy. This tragedy is often compounded when survivors are not given the opportunity to grieve the death in a constructive and supportive manner.[96] Unfortunately, when a child involved with a child welfare agency dies, the number and complexity of relationships, the addition of administrative and investigative responsibilities and the possible involvement of the media can increase the stress experienced by all individuals involved with the death. These issues add additional challenges and additional stress when agency staff attempt to find ways to meet all of the emotional and physical needs of the survivors.[97]

Child Welfare Workers

In conducting the review, the Review Team met with child welfare workers regarding their experiences after the death of a child on their caseload. All of the workers in this study expressed high levels of stress related to the event. This stress increased when the worker was asked to apprehend other children in the home and/or when family members became angry or threatening after the death of their child. Workers expressed the opinion that death may ignite resentment towards the agency and agency staff, increasing the worker's risks of personal harm in the community. This is particularly true in small isolated settings and/or in settings where the worker and their family live in the same community as the victim and their family. Many workers suggested that their fears would be reduced if they had additional training in the area of personal safety.

Section 1.7.4 of the Manitoba Program Standards manual sets out policies regarding the reporting process upon the death of a child known to the child welfare system. This standard, formally known as Section 182, as well as a chart outlining the steps undertaken in reviewing the death of a child known to the child welfare system, is found in Appendix 2 of this report.

Many workers reported that they found the process of writing lengthy reports so quickly after the death was often overwhelming. They felt that the reporting process did not allow them the opportunity to grieve and/or fully understand the issues that led to the death of the child, and that important details were often missed as a result. They felt that the current standards and protocols needed to change to allow them extra time to reflect on the issues that led to the death. Further, they felt that it would be helpful if another agency worker was available to help the front-line worker during this initial crisis period.

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[96] Cook, P., White, D., Ross-Russell (2002). Bereavement support following sudden and unexpected death: guidelines for care. *Archives of Disease in Childhood 87*. Pgs. 36-38.

[97] For the purposes of this section of the report, the term 'survivors' includes family members, foster parents, foster families, other foster children in the home and foster children previously living with the deceased child.

When conducting the review, the Review Team found that a high number of agency staff had not been informed about the death of a child who had previously been on their caseload. It also noted that a very high number of the children in the study were not listed as deceased in the Child and Family Services Information System (CFSIS), and did not have a Section 182 report attached to their file. This placed the Review Team in the uncomfortable position of having to support the worker while attempting to collect additional details related to the circumstances of the death.

While most workers spoke of the high level of stress they experienced after the death of a child, few took advantage of opportunities to debrief and deal with the vicarious trauma of the situation. It appeared that most were offered, but declined counseling from the Employee Assistance Program (EAP), and that some were invited to take a 'couple of holiday days off' if they chose. Most reported that time off was difficult as there was no back-up staff to cover their caseloads while they were away. Others advised that it was sometimes easier to debrief with their co-workers who understood how they were feeling.

However, as one agency administrator reminded us, while the staff may not have taken time off immediately after the death, a high number ended up taking extended time off for stress-related illnesses within a year of the death of their client.[98] This added to the overall costs to the agency with respect to short and long-term disability insurance, and created a much larger problem in attempting to find staff who were able to cover for a sick worker on extended leave.

Overall, there is concern about the inconsistent agency protocols regarding supporting agency staff immediately after the death of a client. The Review Team found that only two agencies had crisis debriefing teams and protocols in place to support survivors in the case of a death or serious injury in the community. The Review Team felt that poor protocols in this area led to higher levels of stress and burnout in agency staff. This burnout not only led to higher levels of short and long-term disability claims, but also compromised the overall care of all children within the agency.

It is felt that protocols regarding the death and/or serious injury of clients needs to be instituted and supported throughout the child welfare sector. This would include some type of crisis debriefing, support for the front-line workers in organizing and writing the 'Section 182' report and follow-up counseling for all involved agency staff.

Likewise affected staff should not be expected to use holiday time to mourn the death of their client. Holidays are designed for workers to relax and recharge with their families and should not be used as a time to mourn the death of a client. The Review Team believes that all staff involved with a crisis such as the death of a child should be provided with up to two paid days' bereavement immediately after the death or serious injury of a child on their caseload.

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[98] An excellent article on the effects of stress in the child welfare field can be found in: Gustavsson, N. & A. MacEachron (2004). When a child welfare client dies: An agency-centred approach. Child Welfare 83 (4). Pgs 317-340.

Recommendation #72

That the four Authorities ensure that all agencies have upgraded their CFSIS files to reflect the death of any children in their care, and that these files be maintained in the system on a weekly basis. Funding for this initiative must be made available to ensure compliance in this area.

Recommendation #73

That the Child Protection Branch draft standards regarding protocols for supporting agency staff in the event of an unexpected death of a client. These protocols should include: a) protocols for informing staff (current and previous), foster parents (current and previous) and family members of the child, b) up to two paid days' bereavement leave for involved staff after the unexpected death of their client, and c) protocols for supporting all survivors including foster siblings of the child who died.

Recommendation #74

That the Child Protection Branch immediately develop a Crisis Debriefing Team that will be dispatched when a child involved with that agency dies or is seriously injured. This team will work closely with agency workers, family, foster parents and other foster children to ensure that all individuals affected by the death are supported and any necessary paperwork is completed.

Recommendation #75

That a module in Crisis Debriefing be added to the Competency Based Training Program as a supplemental training and that at least one staff member from each agency be encouraged to attend this training.

Recommendation #76

That agency staff be given training in safety planning and skills in de-escalating dangerous situations within six months of joining the agency, with refresher courses every two years.

Supporting the Survivors
(Foster Parents, Other Caregivers, Foster Siblings and Birth Families)

Children involved in the child welfare system often have complex lives with a myriad of family-type relationships that may include birth families, foster parents and foster siblings. The death of one of their family members is traumatic for all of these persons. It is often up to the child welfare worker and agency to mediate these relationships in a way in which all feel validated and supported after the death of a child known to the child welfare system.

Certainly one of the more important relationships for the child is their birth family. Family members reported having many unresolved feelings about the agency and guilt related to the child's manner of death. The Review Team believed that some of these issues may have been better resolved if the family was offered counseling after the death of their child.

The death of a child can also be very traumatic for foster parents and group home workers, especially in cases where they find the body and/or in cases in which they were aware of the child's depression or involvement in dangerous activities that ultimately led to their death. In several cases, foster parents expressed anger or frustration when the death resulted from the recent return of the child to their birth family and/or if the child had recently been removed from their home. Conversely, the Review Team was encouraged to hear stories in which foster parents were honoured and supported by the agency and birth family. Team members were told of foster parents, agency staff and birth families actively working together to ensure that every person had an honoured role in the funeral process. In at least one case, the foster mother prepared and presented a 'life book' to the birth family of the deceased child who, in turn, invited the foster family to their reserve community to meet the extended family.

Finally, it was recognized that the families of children living in care are often complex, and many foster children have 'sibling-like' relationships with other foster children in the foster or group home. It is also noteworthy that foster and group homes may have children from a number of agencies living in the same home.

The Review Team recognized the important role that all of the surviving family played in the life of the deceased child. While counseling may be offered to all survivors after the death of the child, agencies are often expected to cover those costs without reimbursement from the Province. This is especially true when the survivor does not have a current legal relationship and/or the survivor is a ward of a different agency than the deceased child. All survivors who request supports to deal with the death of a child currently or previously in their care, ought to be provided with counseling at no cost to that individual or the agency. This may include one-to-one counseling, couple counseling and/or counseling for any children and youth known to the deceased child.

Guidelines for covering the costs of funeral and burial services for the deceased child is set out by the Manitoba Funeral Service Association, with some additional costs covered by the Department of Family Services and Housing. However, agency staff have pointed out that the costs of wakes, funeral meals, travel and accommodation for family members is far below the actual expenditures. In First Nation agencies, these costs can be substantial if families must come from distant places and/or if the family requests a traditional funeral.

Agencies told the Review Team that they often absorb those costs within the agency budget. This creates a situation in which other services may be reduced to cover shortfalls

in this area. It is strongly recommended that the Department of Family Services and Housing raise their supplemental allowances to include the costs of wakes, travel and meals after the funeral.

Recommendation #77

That the Department of Family Services and Housing make up to $5,000 available to agencies to provide counseling for foster parents and group home staff after the death of a child placed in their home or facility. This funding would be dispersed upon presentation to the Department of Family Services and Housing all counseling bills related to the death of that child.

Recommendation #78

That the Department of Family Services and Housing raise their supplemental allowances of up to $1,000, with the submission of receipts, to cover the supplemental costs of: a) funerals, wakes and other traditional ceremonies, and b) travel for immediate family members of children in care to attend the funeral, wake or traditional ceremony.

11. Conclusion

In the past four months the Child Death Review Team reviewed the files of 99 children, met with over 50 child welfare staff and supervisors and representatives of community-based programs for children and youth. The review generated 78 recommendations that ranged from warning about altering baby safety devices to reforms in transition planning for youth leaving the child welfare system. This report is the culmination of that four-month process.

Throughout this review, the team was struck by the commitment of child welfare staff to develop their practice to improve the entire system. This is despite the fact that the child welfare system has gone through unprecedented change that has impacted both the staff workload and the work environment.

In general, the Review Team found no instances in which worker or agency error led directly to the death of a child. It did find that, in many cases, the lack of available community resources and poor coordination between systems created an environment that may have contributed to a death. The review noted that support systems for children and youth must move towards a 'seamless' delivery of services to ensure that no child, youth or family "falls between the cracks" when attempting to access the supports needed.

The review found that, in particular, there is a growing need for available, accessible and affordable mental health services for children and youth. It recognized that adolescents were particularly 'high risk' and made recommendations regarding the development of a better model of support for adolescents and children leaving the child welfare system.

The Review Team also noted that more than half of the children and youth who died within a year of receiving services from the child welfare system had either been or were suspected of being affected by prenatal alcohol and/or drug use. The child welfare system must begin to develop initiatives that will better support pregnant women to reduce their alcohol consumption, as well as to find better ways to support children and youth already affected by FASD.

In reviewing the ages of children in this study, children under five were more likely to have died in their home, while children over 12 were more likely to have died as a result of their activities in the community. This study recommends that the system needs to be more consistent in the use of 'risk estimation' measures when developing case plans for children under the age of five, particularly before placement decisions are made.

Finally, the Review Team believes that increases to prevention funding, which specifically targets 'at risk' youth and adolescents, will result in a reduction of adolescent accidents, homicides and suicides. These recommendations are in keeping with what is known about the importance of developing a 'healthy community' approach for children and families.

Through the process of the review, the team was reminded that, while this report represented a group of children who had died, it does not speak to the numerous children who were seriously injured as a result of childhood sexual and physical abuse, accidents, drug and alcohol use, gang and street involvement and attempted suicides. Perhaps this is a topic for further review at a different time.

In closing, this review began with the death of Phoenix Sinclair. It will end with recommendations that, when implemented, will strengthen supports for children and youth within the child welfare system, as well as children within their family structure. It is hoped that this report will provide some comfort to the families who continue to mourn the death of their children.

Appendix 1: Research Tools

Child Death Review
Review Notes

Assigned #_____

Date of Death_____**Agency Involved**_____

Geographic Location at Death_____

Type of Death: Natural ☐ SIDS ☐ Suicide ☐ Homicide ☐
Accident ☐ Unknown ☐ Undetermined ☐

Method_____

Age of Child at Death: under 1 ☐ 1-4 ☐ 4-8 ☐ 9-12 ☐ 13-16 ☐ 16-18 ☐

Gender: Male ☐ Female ☐

Race: Cree ☐ Ojiibway ☐ Dakota ☐ Aboriginal (other) ☐
Métis ☐ Caucasian ☐ Other ☐ Unknown ☐

_____

Child's Disability: (Check One) None ☐ FASD ☐ ADHD ☐ Mental Health ☐
Physical Disability ☐ Sensory Disability ☐
Intellectual Disability ☐ Medical ☐
Other _____

Prior Suicide Attempts: 0 ☐ 1-2 ☐ + 2 ☐ Unknown ☐ N/A ☐

Prior Suicidal Ideations: Yes ☐ No ☐ Unknown ☐ N/A ☐

Sex Abuse History: Yes ☐ No ☐ Unknown ☐ N/A ☐

Physical Abuse History: Yes ☐ No ☐ Unknown ☐ N/A ☐

Child Substance Abuse: Yes ☐ No ☐ Unknown ☐ N/A ☐

Child Involved in Criminal Justice System: Yes ☐ No ☐ Unknown ☐ N/A ☐

Was the child impaired at death? Yes ☐ No ☐ Unknown ☐ N/A ☐

Child Welfare Involvement

Legal Status: PW ☐ VPA ☐ Family File ☐ Previous ☐

Type of Placement: Child not in Care ☐
Foster Home ☐ Family Home ☐
Relative Placement ☐ Group Home/Facility ☐
Outside Agency ☐ Borrowed Resource ☐
Independent Living ☐ Other ☐

Issues Leading to CFS Involvement: (check all that apply)
Parental Addictions ☐ Child Abuse ☐
Family Violence ☐ Sex Abuse ☐
Neglect ☐ Parenting
Services to Family ☐
Other_____

Length of Time Child in Care:_____ N/A ☐

Number of Placements _____ N/A ☐

Number of Times Reunification Attempted_____ Unknown ☐ N/A ☐

Family of Origin Visits: None ☐ Weekly ☐ Monthly ☐ 2-3 a year ☐
Occasionally ☐ Unknown ☐
N/A ☐

Number of Workers: 1-3 ☐ 4-8 ☐ 8+ ☐ Unknown ☐
N/A

Number of Visits by Worker in 3 Months Prior to Death 0 ☐ 1 ☐ 2-3 ☐ +3 ☐ Unknown ☐
N/A

Caseload of Worker at Time of Death_____Unknown ☐ N/A ☐

Collaterals

Numbers of Presentations to Medical Personnel Prior to Death 0 ☐ 1 ☐ 2 ☐ 3 ☐
3+ ☐ Unknown ☐

Professional Involvement: Therapist/Counsellor ☐ Psychiatry ☐
Extra School Supports ☐ OT/PT/Speech ☐

Other_____
None ☐ Unknown ☐ N/A ☐

Child Death Review
Review Notes

Child's Name_____ Assigned #_____

Birthdate_____ Date of death_____

Address at time of Death_____

Type of Death: Natural ☐ Suicide ☐ Homicide ☐ Accident ☐
Unknown ☐

Agency Responsible for Care_____

Type of Placement: Foster Home ☐ Family Home ☐ Relative Placement ☐
Group Home/Facility ☐ Independent Living ☐ Other ☐

Legal Status: PW ☐ VPA ☐ Family File ☐

Issues with Placement (level of support, number of other children in home, expectations and skill of foster parent etc.)

Worker Aware of Issues/Worker Response (level of service to home, training offered, respite offered etc.)

Agency Adherence to Standards (foster home, foster parents, risk assessment complete etc.)

Outside Professional Involvement (therapists, advocacy organizations, homemakers, etc.)

Child's Needs (disability, level of need, prior issues in placements, sexual orientation, etc.)

Worker Training/Experience - Worker Caseload (education, years of practice, # of active cases etc.)

Last Known Case Plan

Observations

Appendix 2: System Protocol When Child Known to the Child Welfare System Dies

Child Death Occurs*

1 hour/ 10:00 am the next Business Day	If a child in Care, Section 182.1 report is completed by Agency and sent to the Authority and the Branch.	Agency completes 182.1 Authority is notified Branch is Notified Chief Medical Officer Investigates
End of the Next Business Day	If a child is not in care but open to an Agency, Section 182.3 report is completed by Agency and sent to the Authority and the Branch.	Agency completes 182.3 Authority is notified Branch is Notified Chief Medical Officer Investigates
End of the Next Business Day	Upon receipt of Section 182 report where the circumstances of the Childs's death are unusual or likely to draw media attention, the Branch prepares a briefing Note for the Minister.	Branch prepares Briefing Note for the Minister
2 Hours	If serious injury that may result in death or permanent injury occurs to a child in care, Section 182.4 report is completed by Agency and sent to the Authority or Branch.	Agency completes 182.1 Authority is notified Branch is Notified
24 Hours	Agency takes reasonable steps to notify the parent or next of kin of the death or serious injury of a child in care.	Agency notifies Autopsy Chief Medical Officer
48 Hours	Additional information regarding the circumstances of the child's death and agency involvement is forwarded by the agency to the Authority and the Branch.	Authority is notified Branch is Notified
30 Days	Agency conducts a management review of the case and provides a written report to the Authority and the Branch.	Internal Review Authority is notified Branch is Notified

Ongoing	Information concerning the autopsy results, the Agency's internal investigation, the outcome of any policy investigation, and the Agency's plan of action are reported to the Authority and the Branch in a timely manner (Section 182.6).	Agency completes 182.6 Authority is notified Branch is Notified
30-60 Days	Child's death is discussed at the Children's Inquest Committee.	Chief Medical Examiner Office Child Inquest Committee
60-120 Days	Additional information may be sought from the Agency (requested via the Authority) either by letter or, if warranted, through a formal Section 4 review, as a result of the CIRC discussion and the Branch's Analysis of the Case.	Child Protection Branch Section 4 Review Chief Medical Officer may call inquest at completion of criminal trial
120-? Days	Section 10 Report from the Chief Medical Examiner's office received by the Minister and forwarded to the Branch, the Authority, and the Agency. Recommendations are reviewed and a response within 60 days from each identified system is requested by the Branch.	Agency receives report Authority receives report Branch receives report Chief Medical Officer completes Section 10 Report
180- ?? Days	Response from Authority and Agency with regard to Section 10 recommendations is assessed and addressed by the Branch.	Agency response Authority response Branch assesses
180 + Days	Branch reviews and follows up with any recommendations made in Section 4 review or in inquest report (if these activities have occurred).	Branch assesses
240+ Days	Branch responds to the Ombudsman with regard to any recommendations made in an inquest report.	Branch assesses

Appendix 2A: Standard 1.7.4 (formally section 182)

Reporting to Director and Authorities after the Death of a Child

1. **Reporting Agency** – Unless another agency agrees to report the death of or serious injury to a child, the agency that was supervising a child in care or providing services to the family of a child not in care reports the death or injury. If a child was returned to the care of his or her family and the family file was closed within the one year period before the death of a child, the agency that closed the case is responsible for reporting the death.

2. **Reporting Death of Child in Care** – The reporting agency notifies the director and its mandating authority within one hour of learning that a child in care has died or, if the information is received in the evening or on a weekend, by 10:00 A.M. of the next working day. This initial report may be by phone, facsimile or e-mail and must include:

    - name, birth date and legal status of the child
    - names and addresses of the child's parents or guardians
    - name of the placing or guardian agency if different than the reporting agency
    - names of workers and supervisors assigned to the child and the child's family
    - how the reporting agency was informed of the death of the child and by whom
    - known circumstances surrounding the death including date, time, place, and unusual circumstances
    - any information suggesting the child may have died as a result of abuse
    - a summary of agency' involvement with the child and the child's family
    - persons notified by the agency, for example, police, parents, guardian agency
    - any other action taken

3. **Additional Information on Death of Child in Care** – Within 48 hours of the initial report under Standard 1, the reporting agency provides any additional information on the death of a child in care to the director and its mandating authority including:

    - name, address and type of placement at time of death
    - any updates on information given in the initial report

- a detailed statement of the child's placement history and the reporting agency's involvement in the case
- information obtained to date from an investigation by the agency or the police
- names and ages of other children in home where the child who died was placed and whether these children are at risk
- anticipated action by the reporting agency
- whether an autopsy has been or will be performed
- whether charges under the *Criminal Code* (Canada) have been laid or are anticipated

4. **Reporting Death of Child Not in Care** – The reporting agency notifies the director and its mandating authority by the end of the next working day on learning of the death of a child from a family that has received services from the agency during the past year. This report may be by phone, facsimile or e-mail and must include:

    - name, birth date and legal status of the child
    - names, address and involvement of the parents or guardians, and of persons with whom the child was living
    - names of workers and supervisors assigned to the family
    - how the reporting agency was informed of the death of the child and by whom
    - known circumstances surrounding the death including date, time, place, unusual circumstances
    - a summary of agency involvement with the family
    - any information suggesting the child may have died as a result of abuse
    - information obtained to date from an investigation by the agency or police
    - names and ages of other children in the home where the child who died was living and whether these children are at risk
    - if the child had previously been in care, a detailed statement of the child's placement history and the reporting agency's involvement in the case
    - persons notified by the agency, for example, police, parents, guardian agency
    - anticipated action by the reporting agency

- whether an autopsy has been or will be performed
- whether charges under the *Criminal Code* (Canada) are anticipated or have been laid

5. **Reporting Serious Injury to Child in Care** – The reporting agency notifies the director and its mandating authority by the end of the next working day on learning that a child in care has suffered serious injury that could result in death or permanent disability as determined by a physician. This report may be by phone, facsimile or e-mail and must include:

    - name, birth date and legal status of the child
    - names and addresses of the child's parents or guardians
    - name of the placing or guardian agency if different than the reporting agency
    - names of workers and supervisors assigned to the child and the child's family
    - how the reporting agency was informed of the injury to the child and by whom
    - known circumstances surrounding the death including date, time, place, unusual circumstances
    - any information suggesting the child may have been injured as a result of abuse
    - a summary of agency involvement with the child and the child's family
    - information obtained to date from an investigation by the agency or police
    - names and ages of other children in the home where the child who died was living and whether these children are at risk
    - persons notified by the agency, for example, police, parents, guardian agency
    - anticipated action by the reporting agency
    - whether charges under the *Criminal Code* (Canada) are anticipated or have been laid

6. **Notifying Parent or Next of Kin** – On learning of the death of or serious injury to a child in care, the reporting agency or, when applicable and agreed to by both parties, the placing or guardian agency, notifies the child's parent or next of kin within 24 hours or as soon thereafter as reasonably possible on learning of the death of or injury to a child in its care.

7. **Further Reports to Director** – Upon receiving additional information regarding the death or injury to a child, the reporting agency authority of the reporting agency or, if applicable and agreed to by both parties, the authority of the culturally appropriate agency forwards the information to the director. Such information includes:

    - in the case of a deceased child, the results of an autopsy as to the cause of death
    - the results of any medical examinations as to the cause of serious injury
    - the results of agency investigations
    - the results of any policy investigations including the laying of criminal charges
    - any further actions indicated or planned by the agency

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